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ONTARIO

# PROVINCE OF ONTARIO

*Commissioners and committees of enquiry*

## THE MEDICAL SERVICES INSURANCE ENQUIRY

PROCEEDINGS OF THE PUBLIC  
HEARINGS HELD AT THE  
COUNCIL CHAMBERS, CITY HALL,  
WINDSOR, ONTARIO, AT 10.00  
A.M. ON WEDNESDAY, DECEMBER  
4th, 1963.

*1964*

VOLUME

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DATE

DECEMBER 4, 1963.



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MEDICAL SERVICES ENQUIRY

THE RAILROAD HOSPITAL ASSOCIATION

Appearances: O.A. Derrough  
L.R. Hoag  
Council City, Sredman  
Windsor, Ontario, at 10:01  
CHASLES T. PETERSON, D.D.S. no. m.s.  
1901, 1902

Appearances: Dr. Charles T. Peterson

MEMBERS OF BRANCH

THE SOUTHWESTERN ONTARIO PODIATRIC SOCIETY

Appearances: R.J. Tolbert, D.S.C.  
G.J. Gourey, A.J. Gourey

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THE KENT COUNTY MEDICAL SOCIETY

Appearances: Dr. A.C. Henderson  
Dr. J.S. Packham  
Mr. A. A. Nelson

WINDSOR MEDICAL SERVICES INCORPORATED

Appearances: Dr. E. Durocher  
Dr. E.A. Roemmele  
Dr. J.R. Barber  
Mr. W.V. Walpole

Mr. J.P. Mulrooney

Mr. A. Naylor

Mr. HARRY SIMON

Mr. L.L. Whitney

Mr. L.E. Turner Secretary





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Dr. J.R. Barber  
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1 On commencing at PROVINCE OF ONTARIO  
2 MEDICAL SERVICES INSURANCE ENQUIRY  
3 SUBMISSION OF THE RAILROAD HOSPITAL ASSOCIATION  
4 Proceedings of the Public  
5 Hearings held at the  
6 Council Chambers, City Hall,  
7 THE Windsor, Ontario, at 10:00  
8 a.m. on Wednesday, December  
9 4th, 1963. Enquiry have received and  
10 studied the brief you submitted. In accordance with the  
11 MEMBERS OF ENQUIRY:  
12 guide for participation in hearings that was mailed to you,  
13 Dr. J. GERALD HAGEY -- Chairman  
14 it will not be necessary for you to read your brief, but you  
15 Mrs. J.A. AYLEN  
16 do have an opportunity to emphasize or enlarge upon its  
17 Dr. WILLIAM BUTT  
18 conclusions or recommendations.  
19 Miss HELEN CARPENTER  
20 Members of the Enquiry may ask you questions on  
21 Mr. DALTON J. CASWELL  
22 the statements or recommendations submitted in your brief, but  
23 Mr. A. ROY COULTER  
24 you are not to be subjected to examination or cross-examination  
25 Dr. R.J. GALLOWAY  
26 by other persons.  
27 Dr. JOHN HAMILTON  
28 It is not our intention to debate your sugges-  
29 Mr. W.S. MAJOR  
30 tions or recommendations, nor to state the views of this  
31 Miss HELEN McARTHUR  
32 Enquiry on them. Consequently, any opinions expressed in  
33 Mr. P.J. MULROONEY  
34 questions asked or statements made by members of the Enquiry  
35 Mr. CARMAN A. NAYLOR  
36 are intended for clarification only.  
37 Mr. HARRY SIMON  
38 As stated in the instructions, one person is to  
39 Mr. J.L. WHITNEY  
40 act as your spokesman. However, if the spokesman feels that  
41 Mr. L.E. TURNER -- Secretary  
42 another member is better qualified to answer a specific  
43 question from a member of the Enquiry, the spokesman may  
44 -----  
45





PROVINCE OF ONTARIO

MEDICAL SERVICES INSURANCE ENQUIRY

ASSOCIATION OF HOSPITALS

Proceedings of the Public Inquiry  
Hearings held at the  
Council Chambers, City Hall,  
Windsor, Ontario, at 10:00  
a.m. on Wednesday, December 12, 1963.

Report of the Committee

MEMBERS OF ENQUIRY:

OFFICIALS OF THE ASSOCIATION OF HOSPITALS

Dr. J. GERALD HAGEY -- Chairman

Mrs. J. A. AYKEN

Dr. WILLIAM BUTT

Miss HELEN CARPENTIER

Mr. DALTON J. CASWELL

Mr. A. ROY COUTER

Dr. R. J. GALLOWAY

Dr. JOHN HAMILTON

Mr. W. S. MAJOR

Miss HELEN McARTHUR

Mr. P. J. MULROONEY

Mr. GARMAN A. NAYLOR

Mr. HARRY SIMON

Mr. J. L. WHITNEY

Mr. L. E. TURNER -- Secretary





G/dpw 1 --- On commencing at 10:00 a.m. to request the other member to  
2 answer.

3 SUBMISSION OF THE RAILROAD HOSPITAL ASSOCIATION and

4 then proceed. Appearances: O.A. Derrough  
L.R. Hoag

5 The members of the press have requested a copy

6 THE CHAIRMAN: Good morning, gentlemen.

7 Members of the Enquiry have received and  
8 will hand them to the members of the press at the conclusion  
9 studied the brief you submitted. In accordance with the  
10 of your submission.

11 guide for participation in hearings that was mailed to you,  
12 MR. HOAG: I understand that we are not  
13 it will not be necessary for you to read your brief, but you  
14 supposed to read this brief, because it has already been  
15 do have an opportunity to emphasize or enlarge upon its  
16 presented; is that right, sir?  
17 conclusions or recommendations.

18 THE CHAIRMAN: That's right, yes.

19 Members of the Enquiry may ask you questions on

20 MR. HOAG: I think I might say this, that  
21 the statements or recommendations submitted in your brief, but  
22 perhaps our position might be just a little different than  
23 you are not to be subjected to examination or cross-examination  
24 some other open insurers, and that has been brought to my  
25 by other persons.

26 mind here this morning, I believe, by Mr. Whitney, that we

27 It is not our intention to debate your sugges-  
28 are a closed organization, and I think what he means by that  
29 tions or recommendations, nor to state the views of this  
30 is that our coverage is open for railroad employees only, and  
31 Enquiry on them. Consequently, any opinions expressed in  
32 I have brought that up in my brief -- would it be necessary  
33 questions asked or statements made by members of the Enquiry  
34 for us to accept anyone who wants to get into our Association?  
35 are intended for clarification only.

36 With that in mind, we are not here so much to offer any advice.

37 As stated in the instructions, one person is to  
38 We do feel this, that there are a number of advantages by way  
39 act as your spokesman. However, if the spokesman feels that  
40 of standardization of contracts, and so forth, by having a  
41 another member is better qualified to answer a specific  
42 Committee of this nature, and also a set-up, and we're very  
43 question from a member of the Enquiry, the spokesman may  
44 pleased to see that the Ontario Government is allowing the





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SUBMISSION OF THE RAILROAD HOSPITAL ASSOCIATION

Appearances: O.A. Darrough  
L.R. Hoag

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2 answer. a better way of handling it than for the Government to  
3 take over until Will you please identify your spokesman, and  
4 then proceed. Of course, we have a little selfish interest  
5 there, too, because The members of the press have requested a copy  
6 of your brief, and if you have copies with you, perhaps you fit,  
7 will hand them to the members of the press at the conclusion  
8 of your submission, if we can. If the O.R.S.C. took over, is

9 we're out. MR. HOAG: I understand that we are not  
10 supposed to read this brief, because it has already been, of  
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12 as many of our THE CHAIRMAN: That's right, yes.

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25 pleased to see that the Ontario Government is allowing the





1 insurers to carry on under their jurisdiction. We think that  
2 that's a better way of handling it than for the Government to  
3 take over entirely.

4 Of course, we have a little selfish interest  
5 there, too, because if the Government takes over entirely  
6 then we're out, and we're not in the business to make a profit,  
7 we are in for the benefit of our members, and our members  
8 want us to continue, if we can. If the O.H.S.C. took over,  
9 we're out.

10 We cover private and supplementary, which, of  
11 course, you aren't interested in, but we try to continue with  
12 as many of our benefits as we can.

13 I read in last night's paper where the Windsor  
14 Medical is to present a brief this morning, and mention was  
15 made that they have been pioneering for 25 years. Well, we're  
16 over 70 years old, and as far as we know we are the oldest  
17 organization in the field.

18 That doesn't mean that we know more about the  
19 business. We know what we're doing ourselves, and we haven't  
20 been interested in what the other people are doing, but now we  
21 have to be interested in it, whether we want to or not.

22 We've told you in our brief pretty well what  
23 our position is, and we're here to find out more how we can  
24 fit into the picture, and if we have to be open to anybody who  
25 wants to get into our Association, or whether we can still keep



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our position is, and we're here to find out where how we can

fit into the picture, and if we have to be open to anybody who

wants to get into our association, or whether we can still keep





1 it as confined to railway employees.

2 That's about all that I have to say about it,  
3 and, of course, we'll be interested in entering into any  
4 discussion that might come up, sir.

5 THE CHAIRMAN: Thank you, Mr. Hoag. Some of  
6 our members have indicated that they would like to ask you  
7 questions.

8 However, I would like to make a statement rela-  
9 tive to one statement that you made there, and that is that  
10 the members of the Enquiry at this time aren't in a position  
11 to tell you how you can fit into it, or how you can't, or  
12 what our ideas are as to how you will fit into it. These are  
13 things that we will be considering previous to making up our  
14 report.

15 MR. HOAG: I had a separate recommendation that  
16 wasn't included in the brief, and I forgot to say anything  
17 about it. I think that after this organization gets set up,  
18 and gets going in practice, that it would be a good idea to  
19 assign certain agents, or somebody from the Board, to go  
20 around and interview personally each one of the organizations,  
21 and see that their set-up conforms, because we had some diffi-  
22 culty with the O.H.S.C. I mean, we didn't get any personal  
23 assistance in the thing. We had to sort of work it out our-  
24 selves, and I think it would be to the advantage of everybody  
25 if somebody would come down to us and say, "We would like to



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1 look over your system and your records, and see what you are  
2 doing," and say, "You can do this and you can't do this and  
3 so forth, and you will have to make certain changes." I think  
4 that would be very important.

5 Are those the kind of recommendations you are  
6 after, sir?

7 THE CHAIRMAN: Any recommendations you like to  
8 make would be quite in order.

9 MR. MAJOR: Good morning, Mr. Hoag. I was very  
10 interested in your brief, particularly because it includes  
11 only railroad men, and I gather this would include any railroad  
12 employee, whether it is the running trades, the non-running  
13 trades, or the shopmen, and so on?

14 MR. HOAG: Well, it does, to a certain extent.  
15 Actually, our Constitution allows us to take anyone along the  
16 line or right-of-way of the New York Central Railroad, or any  
17 other railroad that has running powers over the New York  
18 Central Railroad in Canada; that is the Canadian division  
19 between Detroit and Buffalo, or any railroad employee who  
20 resides in an area where it is considered to be within our  
21 jurisdiction.

22 MR. MAJOR: Does this include C.P.R. and C.N.R.  
23 employees?

24 MR. HOAG: It would, yes, providing that they  
25 are residing, or working, in our area. One wouldn't want to



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are residing, or working, in our area. One wouldn't want to





1 look after anybody in Saskatchewan, or British Columbia.

2 MR. MAJOR: You stated, sir, that your organiza-  
3 tion had its beginning possibly 70-odd years ago. Did it have  
4 its beginning here in Canada, or is this a New York Central  
5 proposal from the States?

6 MR. HOAG: It had its beginning right here in  
7 Canada, and how this happened is rather interesting. This  
8 is history. I know you will be interested in it, but the  
9 railroad men, especially the train men, used to get together  
10 and find somebody would be sick, and they would take up a  
11 collection and give them some assistance, and somebody came up  
12 with an idea that if they would pay so much a month, then they  
13 would have a fund that would take care of people who needed  
14 assistance through illness, and that was really the starting  
15 of the organization.

16 MR. MAJOR: Very interesting. On page 2 of your  
17 brief, paragraph 4, you put forth here a basic principle of  
18 anti-selection in insurance, and it is well put, and I was  
19 wondering does your plan, when you take on a new subscriber,  
20 have any particular waiting periods, or deterrents, for  
21 immediate coverage?

22 Or, when you take this subscriber on, are they  
23 covered for whatever your coverage includes?

24 MR. HOAG: No. We cover them right from the  
25 start, but that doesn't apply to the family assistance. The



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1 family assistance has to wait two months before the benefits,  
2 but the members themselves, as soon as we take them and they  
3 are accepted, they are covered. We start from the 1st of any  
4 month.

5 MR. MAJOR: Have you got a particular waiting  
6 period, say, for confinements?

7 MR. HOAG: Yes. We do. We have a ten-month  
8 waiting period.

9 MR. MAJOR: From the time that the family is  
10 accepted?

11 MR. HOAG: That is right.

12 MR. MAJOR: But no other waiting periods for  
13 the employees themselves?

14 MR. HOAG: Well, we have a waiting period for  
15 hernias of ten months, and also a ten-month waiting period for  
16 ailments of the female genitary system, and tonsils and adenoids.

17 MR. MAJOR: Are female employees eligible to  
18 join?

19 MR. HOAG: They are, but it's a little different  
20 set-up than the male members. We carry them under what we  
21 call the family group plan. Actually, the two things are sort  
22 of separated, because we have looked after the men for years  
23 and years before we took the females in, and there seems to be  
24 quite an objection amongst the male employees to take females  
25 in. However, that's one of the things that competition brings



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1 to the fore, because we found out that when other insurers are  
2 giving that protection, well, we just have to give it, because  
3 eventually the members want it, and, of course, the members  
4 have the say as to what they want.

5 THE CHAIRMAN: Mr. Hoag, do you have the condi-  
6 tions for insurance for your Association in printed form?

7 MR. HOAG: Yes, we do.

8 THE CHAIRMAN: Possibly if you could leave that  
9 with the Secretary that would take care of questions such as  
10 this.

11 MR. HOAG: Yes. This is a supplement to our  
12 Constitution, and it takes care of all the conditions.

13 THE CHAIRMAN: Mr. Simon, do you have some ques-  
14 tions?

15 MR. SIMON: On the line of Mr. Major's question  
16 on your recommendation 4 on the last page of your brief: you  
17 suggest that it wouldn't be fair for a person to wait until he  
18 is sick, and then apply for insurance, and so on and so forth.

19 Now, what is your position with regards to people  
20 that drop out of your trade, or your industry, or retire? Do  
21 you still maintain him on your list?

22 MR. HOAG: Yes, we do, and we found out that we  
23 had to, because -- at one time we didn't, but the New York  
24 Central in this last few years have reduced their staff to a  
25 considerable extent. They are only operating, I would say, not

to the fore, because we found out that when other insurers are giving that protection, well, we just have to give it, because eventually the members want it, and, of course, the members have the say as to what they want.

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Central in this last few years have reduced their staff to a

very small staff, and only operating, I would say, not





1 more than half of the employees that they used to, and some of  
2 those members had belonged for years and years, and it didn't  
3 seem fair after all those years, when maybe they couldn't get  
4 anything to take its place, that they should be required to  
5 drop out. So we have been allowing them to continue as long  
6 as they can keep their payments up, but, of course, if they  
7 drop we can't take them back, because they aren't railroad  
8 employees at the time, unless they come back to work again.

9 MISS CARPENTER: We were wondering when you  
10 examined Bill 163 did you feel that on the basis of this Bill  
11 you could continue to operate medicare insurance, or did you  
12 feel you would have to go out of business if Bill 163 were  
13 passed?

14 MR. HOAG: Well, it was our hope that we could  
15 continue in business, and, of course, in looking over the Bill  
16 there were certain portions of it, for instance, such as I  
17 brought out in this brief, that might require us to take any-  
18 one who wanted to come in, and that's the point that we wanted  
19 to sort of get some definite information whether in our case  
20 we were maybe a little different than anybody else. I suppose  
21 everybody feels the same way: "Well, my case is a little  
22 different," and, of course, we're taking that attitude, that  
23 maybe it is, and at our meeting with the Board of Directors  
24 it was definitely stated by our Directors that we wanted to  
25 stay in business, and we're willing to comply with regulations,



those members had belonged for years and years, and it didn't  
seem fair after all those years, when maybe they couldn't get  
anything to take its place, that they should be required to  
drop out. So we have been allowing them to continue as long  
as they can keep their payments up, but, of course, if they  
drop we can't take them back, because they aren't entitled  
employees at the time, unless they come back to work again.  
MISS GARRETT: We were wondering when you  
examined Bill 163 did you feel that on the basis of this Bill  
you could continue to operate medicare insurance, or did you  
feel you would have to go out of business if Bill 163 were

MR. HOAG: Well, it was our hope that we could  
continue in business, and, of course, in looking over the Bill  
there were certain portions of it, for instance, such as I  
brought out in this brief, that might require us to take up  
one who wanted to come in, and that's the point that we wanted  
to sort of get some definite information whether in our case  
we were maybe a little different than anybody else. I suppose  
everybody feels the same way: "Well, my case is a little  
different," and, of course, we're talking that attitude, that





1 just whatever we have to do, why, we'll go along with it.

2 MISS CARPENTER: This was the main point you  
3 found difficult to accept, the number of persons you would  
4 have to insure?

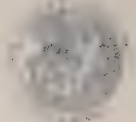
5 MR. HOAG: Well, for instance, if we had to  
6 take an outsider who had nothing to do with the railroad at  
7 all, well, that would put us in a lot different position than  
8 we're in at the present time.

9 MR. MULROONEY: Could you tell us, Mr. Hoag,  
10 whether your Association is incorporated, legally?

11 MR. HOAG: Well, now that goes back so far that  
12 I would almost have to look into the back records, really.

13 No, we never have been licensed by the Insurance  
14 Department, and I don't know why, but we never have been. We  
15 have never been asked to be licensed, and I suppose the reason  
16 for that is because -- we've had dealings with the Insurance  
17 Department. They know we exist, and all that, but we've never  
18 been required to be licensed, and they've never had any juris-  
19 diction over our benefits or premiums, and I suppose that it's  
20 been the thought, "Well, this is a railroad outfit, and they're  
21 running their own affairs," and I would say now under this new  
22 set-up that we're out of that jurisdiction, and we're definitely  
23 under control of the new government-sponsored plan.

24 MR. MULROONEY: It appears that you're operating  
25 pretty much as a friendly society.



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1                   MR. COULTER: If a person leaves the district  
2 and has been a contributor of yours for a number of years, can  
3 he still stay covered in your group?

4                   MR. HOAG: Yes, that's right. We have allowed  
5 them to continue as long as they were members, but we felt  
6 actually that we would be getting into trouble with the  
7 Insurance Department if we took in persons who weren't  
8 connected with the railroad service at all, but we thought  
9 that it was only right that once they became members they  
10 should be allowed to continue, because a lot of those men  
11 didn't leave the service because they wanted to, but because  
12 of a reduction in staff, and so forth.

13                  MR. WHITNEY: There's no drop-out age at all,  
14 then? If they retire at 60 and they live to be 80 and pay  
15 their premiums, they would still stay in the plan?

16                  MR. HOAG: We have 150 widows that were left,  
17 and they come in and keep up their premiums, and they're the  
18 best payers we have. They always keep their premiums up.

19                  MR. CASWELL: Do they pay the same premium, or  
20 is there an increase when they leave the railway?

21                  MR. HOAG: No, we always charge the same, and  
22 at one time we felt that the younger employees coming in  
23 would help to keep the older ones, but now we're all in the  
24 older age group, but we still have a pretty good set-up, and  
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1 continue with it if we can.

2 MR. WHITNEY: Do you work on an annually  
3 balancing budget, an annual assessment basis to balance your  
4 budget, or do you maintain somewhat of a reserve?

5 MR. HOAG: Well, we have a reserve. Our  
6 reserve -- as I said, we operate actually the family group as  
7 a separate unit to the members' group, and we do that because  
8 some members don't have their families covered, and they  
9 thought at the time when the women and children come into this  
10 they're going to put us on the rocks, so we insist that they  
11 pay their own way, so, on paper, we have operated them as two  
12 units; the family unit and the members' unit.

13 MR. WHITNEY: What I'm leading up to is this,  
14 something that you have touched on, and that is that the Bill  
15 as it now stands calls for licensing of all carriers who would  
16 be involved in issuing standard contracts. I suppose under  
17 licensing there may be certain minimum requirements by the  
18 Superintendent of Insurance. There may be certain information  
19 required, basic information, and proof of observance of stan-  
20 dard contract requirements.

21 Does this bother you at all?

22 MR. HOAG: Well, the only way that it bothers  
23 us is that, supposing the Superintendent of Insurance said,  
24 "Well, you are out because you aren't complying with all the  
25 regulations of the Act"; we wouldn't mind if he would say,



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2 continue you will have to meet certain requirements," and we  
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4 we're here. A lot of people don't know anything about us.  
5 As you say, we're closed, and working on our own, but we're  
6 quite willing to do what we can to work with anybody else.

7 MR. WHITNEY: Do you issue any sort of financial  
8 statement to your members every year?

9 MR. HOAG: Yes.

10 MR. WHITNEY: So that that much information is  
11 made public, in a sense?

12 MR. HOAG: What we do, instead of operating on  
13 a budget, we go by our last year's financial statement, and we  
14 keep a record of each classification of coverage, and we know  
15 whether one classification is going behind, or going ahead, and  
16 so forth.

17 In this last year we had what we call a basic  
18 coverage, which is for the members, and it's pretty hard to  
19 keep it balanced financially, because, well, we cover so many  
20 things. I mean, it's such a broad coverage, with so very few  
21 limitations, so we did establish a policy during the year that  
22 if any one group would go behind a thousand dollars we would  
23 put on a dollar-a-month assessment until that was made up, and  
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whether we will be able to carry that on after the Government supervision comes into effect. We would like to do it, because it keeps our dues down to a minimum.

MR. WHITNEY: Do you have a first-dollar coverage? Is there any co-insurance, or deductible?

MR. HOAG: No, we don't have any deductible.

THE CHAIRMAN: Questions like that might be answered in the regulations that we have.

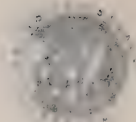
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In the event that your employee lapses his coverage by non-payment, do you have a reinstatement period?

MR. HOAG: The way we operate is this, that a member's dues are supposed to be paid, and if they aren't paid he doesn't get benefits, but we can't suspend him for six months, although he is still not beneficiary, and in order to get back into benefits he has to pay his back dues and if he is over two months in arrears, then we can go back 15 days, and chop this off what he had beneficiary for.

I think you'll find this in almost any insurance, that they wouldn't come in and say, "I want to resign." You just don't see them. We notify a member every month if he is in arrears, so that actually if he gets suspended it's his own





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1 fault.

2 DR. GALLOWAY: How many people are there insured,  
3 and to whom do you pay the benefits, the patient or the doctor;  
4 and on what basis are the medical expenses paid; and is there  
5 any income protection in your benefits?

6 MR. HOAG: We have no income protection. What  
7 was your first question?

8 DR. GALLOWAY: To whom do you pay the benefits,  
9 the patient or the doctor?

10 MR. HOAG: Well, we like to pay our benefits  
11 right to the doctor.

12 Now, so far as our members are concerned, we  
13 pay the full coverage, O.M.A., whether they go to a specialist  
14 or who they go to, but as far as the family group is concerned,  
15 when we took that over we kind of profited by experience in  
16 operating something that there is no limit to at all. It's  
17 pretty difficult to try and carry on financially if you haven't  
18 got a limitation any place. So we do make a certain allowance.  
19 We have two family groups, and one of them is allowed so much  
20 for surgery, and so much for other things, you see, and then  
21 we pay according to that, and if they have a second operation  
22 for the same thing, then we allow them two-thirds of what we  
23 would ordinarily allow for the first one, and so forth.

24 DR. GALLOWAY: Is that described in this little  
25 pamphlet?



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2 that there has been a little change in respect to that, that  
3 we used to allow so much for the first, and two-thirds for the  
4 second, and one-third for the third, so we changed that, and  
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12 way. So we see that we pay for the most expensive coverage in  
13 full.

14 DR. GALLOWAY: Are you referring to one, two  
15 and three under a single hospital admission, or throughout the  
16 course of the year?

17 MR. HOAG: Well, we go by ailments, actually.  
18 There isn't any limitation by the year, but there is limitation  
19 on each ailment.

20 We have medicine, by the way, and we have a  
21 limitation there, too, and we have to keep a record of that,  
22 because I read in the paper where you are a little interested,  
23 or not interested -- I don't know which -- in the medicine  
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5 then, of course, you run into a little difficulty, because  
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7 but we explain to them, "Well, that's only for that ailment now.  
8 If you have another ailment, you're still allowed to draw on that."

9 THE CHAIRMAN: I believe Dr. Galloway asked how  
10 many members you had.

11 MR. HOAG: Well, we're operating now on about  
12 900 members. That's just about half of what we had, say, about  
13 ten years ago, but it's all in view of the fact that we have  
14 made so many reductions in the staff.

15 Those are actual members, and in addition to  
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18 Then, as I told you, we have about 150 widows  
19 that we carry as well.

20 DR. BUTT: Mr. Chairman, I would like to congratu-  
21 lulate Mr. Hoag. I think he has certainly shown us perhaps  
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1 almost impossible for you to operate if you conform to the  
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3 MR. HOAG: No. We feel, actually, that our  
4 coverage is pretty broad, and I don't feel -- well, we might  
5 have to cut off some limitations, and that's one thing, of  
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7 possible to have any kind of limitations at all. I'm not just  
8 sure of that.

9 There are some things that we're not a hundred  
10 per cent sure what they mean.

11 DR. BUTT: Could you make it available to other  
12 people? In other words, universally available. Could you  
13 still operate?

14 MR. HOAG: Other than railroad employees, do  
15 you mean?

16 DR. BUTT: Yes.

17 MR. HOAG: Well, we discussed that, and, of  
18 course, when we're limited to just railroad employees we don't  
19 have a chance to expand the way we should be able to, and it's  
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6 MR. HOAG: Well, of course, we make our collec-  
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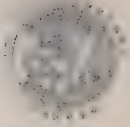
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13 In other words, who are railroad employees but  
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15 MR. HOAG: Well, of course, you see we've been  
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21 Then, down around Windsor you have the Windsor  
22 Medical, and that's a local thing, which is very good, and  
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1 belong that don't, but it isn't compulsory. I mean, it's  
2 optional. They don't have to belong.

3 DR. BUTT: I realize that.

4 MR. HOAG: ~~Does that~~ answer your question?

5 DR. BUTT: Well, more or less, yes. Some of  
6 them have other coverage is what you are saying?

7 MR. HOAG: That's right.

8 MR. SIMON: Do your members have other medical  
9 coverage, or is this the only coverage that they have?

10 MR. HOAG: Some of them have, yes, and that's  
11 another problem, too, but it's my understanding that after  
12 this new plan goes into effect, that although I imagine it  
13 will be like the O.H.S.C., that if you want to carry two or  
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17 who have been covered under the Travelers', they don't mind  
18 being covered under the Travelers'. They can't help it. They  
19 have to be, anyway, because it's part of their working agree-  
20 ment, but when the time comes to retire, they don't want  
21 to have to keep up the premiums that they would have to pay,  
22 and the reduced benefits, too, at the time of retirement.  
23 Therefore, they have been keeping up the Railroad hospitaliza-  
24 tion for the fact that maybe in a few years they would be  
25 retired, and they would stay with us, and drop the other.



belong that don't, but it isn't compulsory. I mean, it's

optional. They don't have to belong.

DR. BUTT: I realize that.

DR. BUTT: Well, more or less, yes. Some of

them have other coverage is what you are saying?

MR. HOAG: That's right.

MR. SIMON: Do your members have other medical

coverage, or is this the only coverage that they have?

MR. HOAG: Some of them have, yes, and that's

another problem, too, but it's my understanding that after

this new plan goes into effect, that although I imagine it

will be like the O.H.S.G., that if you want to carry two or

three insurances, that's your business, but you can only

collect on one, and I think that will make some difference,

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1                   We have under consideration at the present time  
2 that possibly we might, where there is other coverage like that,  
3 we might give protection that would have nothing to do with any  
4 of the double coverage features, and allow them to continue at  
5 a minimum rate to be members, and at the same time they would  
6 be beneficial under certain categories that would have no  
7 duplication aspect.

8                   DR. GALLOWAY: Have you come to any conclusion  
9 what those other areas would be?

10                  MR. HOAG: No, we haven't, actually. We have,  
11 oh, written down a few things like maybe dental care, and  
12 chiropractic care, and osteopaths, and maybe medicine might  
13 be one, because Travelers' don't carry any medicine,  
14 and as long as we're in that line, anyway, well, perhaps we  
15 could carry on and make up some kind of a contract that they  
16 could be covered under until the time that they are retired,  
17 and then we would agree to accept them for full coverage.

18                  MR. CASWELL: Does your Association now cover  
19 dental and chiropractic care?

20                  MR. HOAG: No.

21                  MR. CASWELL: You would consider that for the  
22 future?

23                  MR. HOAG: No. That was in answer to a question  
24 what we might consider covering. Those are fields that could  
25 be explored, and we might do something about it.

26                  MR. WHITNEY: Mr. Chairman, if I may say some-  
27 thing, and be careful how I say it, I think it is only fair to

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1 indicate to Mr. Hoag that as the Bill is now proposed, it is  
2 in its second reading, it is not final. It does suggest that  
3 there is a standard contract with minimum coverages, and cer-  
4 tain standard conditions, somewhat the same idea as the stan-  
5 dard conditions in a fire insurance policy.

6           You were worried about minimum coverages, and  
7 what you could do about it. This suggests a bottom in the  
8 type of coverage, and the conditions of the standard contract,  
9 with the right to offer all the frills above, the frills being  
10 elected, and the suggested idea of the standard being obliga-  
11 tory. The waiting periods, and all these things, would be uni-  
12 form under this Bill, as proposed.

13           MR. HOAG: Yes.

14           MR. WHITNEY: You are aware of that, are you?

15           MR. HOAG: Yes, and we think actually as far  
16 as our members are concerned, we are fully living up to our  
17 requirements now, and more than that as far as that goes, but  
18 as far as the plan was concerned, we never have felt like  
19 taking over the home and office calls, but now we realize  
20 that we have to give that coverage if we are going to continue.

21           For one thing, we haven't really completed  
22 anything, actually, because we wanted to make sure just exactly  
23 what we could do, and what we couldn't do, but we realize that  
24 we do have to give home and office calls, and I suppose that  
25 will be for first-dollar.



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1 MR. WHITNEY: Yes, and it also implies here  
2 that there will be, the suggested Bill implies that there  
3 will be a maximum premium for the standard contract, above  
4 which you can't go for standard coverage, but which you can  
5 compete, premium-wise, below the maximum.

6 You are aware of that?

7 MR. HOAG: But you have to guarantee that  
8 premium rate for the first year; is that right?

9 MR. WHITNEY: Well, it has two years now, with  
10 review suggested in two years after experience is gained, and  
11 so on.

12 MR. HOAG: Well, would you consider -- I don't  
13 know whether I should ask you this -- what would you consider  
14 that our present method now, would it be acceptable just at  
15 the present time, that we operate on our present schedule,  
16 with the understanding that if any group goes behind that we  
17 can put on a special assessment to make that up?

18 THE CHAIRMAN: I am afraid an answer on that  
19 might be accepted as a ruling, which we wouldn't want to indi-  
20 cate, I think, would we, Mr. Whitney?

21 MR. WHITNEY: I would stay away from that, Mr.  
22 Chairman.

23 I'll just say that you are probably not alone  
24 in the situation, and this problem is going to come up again,  
25 and sooner or later the Committee is going to have to deal with



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TORONTO, ONTARIO

79

1 it.

2 MR. MAJOR: Mr. Hoag, forgetting the assessment,  
3 what is your base rate now for the single male employee?

4 MR. HOAG: Three dollars a month, and that gives  
5 him the use of the doctor, and ambulance, and out-patient  
6 hospital service, x-rays, laboratory service.

7 MR. MAJOR: And it covers home and office calls?

8 MR. HOAG: It does.

9 MR. MAJOR: What is your rate, then, for the  
10 family?

11 MR. HOAG: We have a rate of \$1.75 for what we  
12 call the D-2, and then we have another class, D-1. That's a  
13 dollar-and-a-quarter a month, and then we charge extra for  
14 children up till 16. We allow the children to continue as long  
15 as they're dependent on their parents. Sometimes it doesn't  
16 work out, because we have no way of finding out sometimes when  
17 they become independent, and sometimes they're married, and  
18 they're married for two years, and in that case, of course,  
19 we feel that our Constitution covers it, because we tell them  
20 that they can't continue after they are married, and we refund  
21 the money that has been taken on behalf of those people.

22 MR. MAJOR: These rates are in addition to the  
23 \$3 that you are collecting from the employee?

24 MR. HOAG: Yes.

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1 calls for these dependants?

2 MR. HOAG: That's right, it doesn't, nor medi-  
3 cine. We don't allow any medicine for the families.

4 DR. BUTT: Mr. Hoag, would you have any idea  
5 of your percentage, say, over 65 and under 65?

6 MR. HOAG: Well, I would say -- could I give  
7 you a guess?

8 DR. BUTT: Yes.

9 MR. HOAG: We don't know that exactly, but I  
10 would say that over-65's would comprise about a third of our  
11 membership.

12 MR. SIMON: Have you still got some of the  
13 original ones?

14 MR. HOAG: No. I can remember when we did. No.  
15 I've been with this organization since '28. That's another  
16 reason why I hope we can stay in business, for a while.

17 MR. DERROUGH: We had a hospital association in  
18 St. Thomas before there was a hospital.

19 MRS. AYLEN: Had your Association anything to  
20 do with the establishment of the hospital in St. Thomas, and  
21 do you have any representation on the Board?

22 MR. HOAG: No, we did used to have a kind of an  
23 agreement with the hospital, and we have what we call a rail-  
24 road ward in St. Thomas, but inasmuch as the hospitals, actually  
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2 They didn't feel that we should have any  
3 consideration over and above any ordinary person, and therefore  
4 we didn't feel that we cared anything about maintaining a ward.  
5 It wasn't our furniture, anyway. We did have furniture in the  
6 very first hospital that was there, and what happened to it  
7 when the hospital was dismantled nobody knows.

8 MRS. AYLEN: It was probably worn out.

9 MR. HOAG: I don't think it would be any use now.

10 MISS McARTHUR: Do the rates rise rapidly as  
11 this proportion of over-65 grows?

12 It seems to me that this must have happened in  
13 the last few years. Have you noticed a marked problem in rate  
14 structure?

15 MR. HOAG: Yes. Well, you see, in industrial  
16 work usually the younger people get laid off, and I think  
17 that's wrong. It should be the older people, and put on  
18 pension, but just the same ---

19 MR. SIMON: I'm glad you made your last remark.

20 MR. HOAG: But I think that younger people who  
21 are raising a family, and maybe buying their home, need their  
22 job more than maybe the older people, who are more or less  
23 established, provided the older people are sure of some kind  
24 of separation allowance, and in the railroad service they do  
25 have. This is a United States railroad, and if you are



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24 have. This is a United States railroad, and if you are



1 unemployed you entitled to consideration from the Railroad  
2 Retirement Board.

3 THE CHAIRMAN: I gather that the questions are  
4 exhausted. Thanks very much, gentlemen.

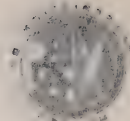
5 MR. COULTER: Is anyone living in the United  
6 States covered under your plan?

7 MR. HOAG: Yes, we do have some people who have  
8 moved to the United States, and what we do, we tell them that  
9 we will give them the same coverage there as we would here,  
10 and we know that the medical services there are much more than  
11 they are here, but just the same they are paying the same  
12 money, and if they pay their premiums in United States money,  
13 we pay their bill in United States money, but if they don't,  
14 why, we just issue a cheque on our bank account, and it's a  
15 question between the person who gets the cheque and the people  
16 who owe them the money.

17 When the P.S.I. -- I don't know whether we have  
18 any right to discuss another plan or not, but we're all in the  
19 same boat here, apparently. The doctors allow 10% reduction  
20 from the fee, and they will accept that in full payment, and  
21 we think that's kind of unfair competition. We feel that if  
22 we're all in this together, and we're supposed to pay the fees,  
23 why should not everybody pay it?

24 Dr. Butt probably might be able to answer that.

25 DR. BUTT: Did you say I might be able to answer



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2 MR. WHITNEY: Do you agree with that, Dr. Butt?

3 DR. BUTT: Well, I would be committing myself,  
4 wouldn't I?

5 THE CHAIRMAN: As I stated at the beginning,  
6 we're not here to debate these issues.

7 MR. HOAG: Well, I hope you will record that as  
8 a question coming from our Committee.

9 THE CHAIRMAN: Thank you, gentlemen. I believe  
10 that your organization could very rightfully be called a  
11 friendly society.

12 MR. HOAG: Thank you very much.

13 THE CHAIRMAN: Is Dr. Peterson present?

14  
15 SUBMISSION OF CHARLES T. PETERSON, D.D.S.

16 Appearance: Dr. Charles T. Peterson

17 THE CHAIRMAN: Dr. Peterson, were you here when  
18 I read the instructions to the first delegation?

19 DR. PETERSON: No, sir, I wasn't.

20 THE CHAIRMAN: I would like to draw them to your  
21 attention.

22 Members of the Enquiry have received and  
23 studied the brief you submitted -- this is the original one.  
24 The second one hasn't been submitted. I received that, of  
25 course, only the other day. In accordance with the guide for

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2 be necessary for you to read your brief, but you do have an  
3 opportunity to emphasize or enlarge upon its conclusions or  
4 recommendations.

5                   Members of the Enquiry may ask you questions on  
6 the statements or recommendations submitted in your brief, but  
7 you are not to be subjected to examination or cross-examination  
8 by other persons.

9                   It is not our intention to debate your sugges-  
10 tions or recommendations, nor to state the views of this  
11 Enquiry on them. Consequently, any opinions expressed in  
12 questions asked or statements made by members of the Enquiry  
13 are intended for clarification only.

14                   So you may proceed.

15                   DR. PETERSON: Dr. Hagey, members of the Commis-  
16 sion: the brief I present is that I believe that oral diseases  
17 are an infective mechanism. We have certain proof now. More  
18 research has to be done, and I believe that we should have a  
19 medical approach to oral diseases.

20                   I think the oral health services should not be  
21 a technical service, but should come under a medical health  
22 plan for the Province of Ontario. Now, I have certain articles  
23 here to back up the idea of oral services, in which Dr. Hamilton,  
24 Dr. Galloway and Dr. Butt would be very interested. I have  
25 also got certain ones that have to do, more in layman's terms,



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also got certain ones that have to do, more in layman's terms,



1 with the different problems. I feel that a technical service  
2 would not answer the problem of dental care in the Province of  
3 Ontario.

4 Here is a brief note from Dr. Cox of the  
5 Children's Hospital:

6 "When one considers how frequently systemic  
7 diseases, whether due to infection, defective  
8 nutrition, hormonal imbalance, blood dyscrasia,  
9 or simply old age, are accompanied by distinct  
10 pathological lesions within the oral cavity,  
11 particularly in the gums and the supporting  
12 tissues of the teeth, one wonders why every  
13 physical examination does not include a report  
14 of the findings in these supporting tissues."

15 Then I have other things to point out in terms  
16 of dental services. This is a copy from the Minister of Health  
17 in London England, comparing 1959 and 1960 dental treatments.  
18 The number of teeth extracted in 1960 was 11,033,000 teeth;  
19 that was permanent teeth. There were 23,000,000 fillings done  
20 and there were over two and a half million dentures made in  
21 London England. That was just England and Wales.

22 We have different reports here. It was the  
23 Carnegie Report that was done in 1926 -- the Giles Report. I  
24 haven't got the latest one on the Council of Education that  
25 was just made.

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1 But I feel that oral disease is an infective  
2 disease, that by research there is no reason why we cannot find  
3 out what is causing it and have control. This is not just  
4 periodontal disease. I believe that tooth decay is also and  
5 that you cannot treat the tooth only -- it must be the tissues  
6 as well.

7 THE CHAIRMAN: Thank you. The members of the  
8 Enquiry may have some questions.

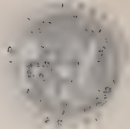
9 DR. HAMILTON: Dr. Peterson, your brief covers  
10 a very wide field: medical education, research, the theories  
11 and the cause of oral disease, dental practice and prevention.  
12 But I would ask you if you would explain what the relevance  
13 of this to Bill 163 is?

14 DR. PETERSON: In essence -- I am sorry. What  
15 is Bill 163?

16 THE CHAIRMAN: This is the bill that we have  
17 been charged to investigate with people who have an interest  
18 in it, relevant to medical services insurance. It has been  
19 placed before the legislature of the province and it has had  
20 two readings and that is the sole purpose of this Enquiry.

21 DR. PETERSON: I am sorry. I feel that the  
22 treatment of oral diseases should be approached from a medical  
23 treatment of the disease and it should come under medicare  
24 plans.

25 DR. HAMILTON: You are asking then that dental



But I feel that oral disease is an infective disease, that by research there is no reason why we cannot find out what is causing it and have control. This is not just periodontal disease. I believe that tooth decay is also and that you cannot treat the tooth only -- it must be the tissues as well.

THE CHAIRMAN: Thank you. The members of the Endulry may have some questions.

a very wide field: medical education, research, the theories and the cause of oral disease, dental practice and prevention. But I would ask you if you would explain what the relevance of this to Bill 103 is?

DR. PETERSON: In answer -- I am sorry. What is Bill 103?

THE CHAIRMAN: This is the bill that we have been charged to investigate with people who have an interest in it, relevant to medical services insurance. It has been placed before the legislature of the province and it has had two readings and that is the sole purpose of this Endulry. DR. PETERSON: I am sorry. I feel that the

treatment of oral diseases should be approached from a medical treatment of the disease and it should come under medical

plans. DR. HAMILTON: You are asking them that dental



1 treatment should be included in the medical services made  
2 available under Bill 163?

3 DR. PETERSON: Yes.

4 DR. HAMILTON: Thank you very much, Dr.  
5 Peterson. I have no further questions.

6 THE CHAIRMAN: Do any other members of the  
7 Enquiry have any questions?

8 Thank you very much, Dr. Peterson.

9 Is the delegation from the Podiatric Society  
10 present? Is the delegation from the Southwestern Ontario  
11 Podiatric Society not present?

12 Is the delegation from the Kent Medical Society  
13 here?

14 Is there anyone here who wishes to be heard?

15 Let us recess for ten minutes.

16  
17 ---Short recess.

18 THE CHAIRMAN: Is the delegation from the South-  
19 western Ontario Podiatric Society present? Would you like to  
20 come forward to the table, please.

21

22 SUBMISSION OF  
23 THE SOUTHWESTERN ONTARIO PODIATRIC SOCIETY

24 Appearances: R. J. Tolbert, D.S.C.  
G. J. Courey

25 THE CHAIRMAN: Gentlemen, I will read the





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20 Appearances: R. J. Tolbert, D.S.C.

21 THE CHAIRMAN: Gentlemen, I will read the



1 instructions which are read to all delegations appearing before  
2 the Enquiry:

3 "Members of the Enquiry have received and  
4 studied the brief you submitted. In accordance with the guide  
5 for participation in hearings that was mailed to you, it will  
6 not be necessary for you to read your brief, but you do have  
7 an opportunity to emphasize or enlarge upon its conclusions or  
8 recommendations.

9 Members of the Enquiry may ask you questions on  
10 the statements or recommendations submitted in your brief, but  
11 you are not to be subjected to examination or cross-examination  
12 by other persons.

13 It is not our intention to debate your sugges-  
14 tions or recommendations, nor to state the views of this Enquiry  
15 on them. Consequently, any opinions expressed in questions  
16 asked or statements made by members of the Enquiry are intended  
17 for clarification only.

18 As stated in the instructions, one person is to  
19 act as your spokesman. However, if the spokesman feels that  
20 another member is better qualified to answer a specific  
21 question from a member of the Enquiry, the spokesman may receive  
22 the Chair's permission to request the other member to answer.

23 Would you tell us now which one is to be  
24 spokesman?

25 MR. COUREY: My name is Courey. I am a solicitor.



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MR. COURRY: My name is Courry. I am a solicitor





1 I have with me Richard J. Tolbert, who is a Podiatrist prac-  
2 tising in the city and I think there may be some questions more  
3 beneficially answered by him.

4 THE CHAIRMAN: Thank you. Would you like to  
5 proceed, Mr. Courey.

6 MR. COUREY: Mr. Chairman and Members of the  
7 Enquiry: First I would like to thank you for the opportunity  
8 of appearing here and presenting this brief today and I would  
9 like to thank Mr. Turner, the Commission Secretary, for his  
10 assistance in supplying us with information necessary for the  
11 preparation of the brief which we have before you today.

12 Now, it is our respectful submission that the  
13 public interest cannot be other than very well served by  
14 including podiatrists' services under Bill 163.

15 I must confess personally that until becoming  
16 involved in this matter, my own knowledge of this field was  
17 very negligible and, frankly, from discussions with many others,  
18 I think we can draw the conclusion that the public knowledge  
19 of the merit of their work is somewhat superficial. I fully  
20 appreciate the commission, likely before this date, and  
21 certainly is by this time, very well acquainted with the  
22 podiatrists' work and service and his qualifications.

23 Without going into any detail, I would however  
24 like to deal generally now with the services which the  
25 podiatrist performs and the value of the particular service.



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proceed, Mr. Courty?

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1 As you know, in Ontario the podiatrist is licensed to treat  
2 any ailment, disease or defect of the human foot. The faculties  
3 teaching podiatry, which are recognized by the Ontario Board,  
4 are staffed with podiatrists, medical practitioners and doctors  
5 of philosophy of the basic sciences. Generally speaking, their  
6 curriculum consists of a pre-professional course of two years,  
7 after Grade 12, or one after Grade 13, and four years pro-  
8 fessional course.

9 I will leave with you, if it might be of interest,  
10 catalogues from two of their institutions which deal with the  
11 curriculum and the faculty.

12 I think the curriculum was dealt with in the  
13 brief submitted by the Ontario Association and we needn't dwell  
14 on that point today at all.

15 Now, in essence, the co-operation of the medical  
16 profession in podiatric teaching institutions and the increasing  
17 number of clinics established in hospitals in the province --  
18 in Toronto there are two in the Toronto General Hospital, one  
19 each in St. Joseph's Hospital, Baycrest Hospital, St. Michael's  
20 Hospital and Toronto Western Hospital. In London there is  
21 one podiatric clinic in St. Mary's Hospital and here in the  
22 City of Windsor at Riverview Hospital, which is a hospital for  
23 the aged and infirm person, a clinic has been established and  
24 it has had, I am assured, very remarkable success in assisting  
25 hitherto bed-ridden patients to become and remain ambulatory.



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1 We believe that the commendations of these hospitals are  
2 adequate evidence of the importance and value of the podiatrist's  
3 services. The work of the podiatrist in the treatment of  
4 diabetic foot is one area in which his services are extra-  
5 ordinarily important and very beneficial and I would, if I may,  
6 leave with the Commission a thesis on the Conservation of the  
7 Diabetic Foot, prepared by the Diabetic and Podiatric Clinics  
8 of Georgetown University Hospital and the Department of Medicine  
9 of Georgetown University. It deals, and it sets out very  
10 clearly, with the nature of the service which the podiatrist  
11 performs in this area, the co-operation between the medical  
12 profession and the podiatrist in this area.

13 I might also leave with the Commission a bro-  
14 chure of St. Luke's Children's Hospital, which sets out the  
15 scope of the podiatrist's practice, the nature of his service  
16 and the co-operation between the profession in this area.

17 If I may proceed to the conclusion of our brief,  
18 we quite properly feel that Bill 163 does include medical and  
19 surgical care of the foot. It does not, however, in its present  
20 form, cover these services if required by a podiatrist who, we  
21 say, is legally entitled and licensed under the law, as well as  
22 properly qualified, to perform these services. Now, no doubt,  
23 in so doing, he is competing, if one would call it that, with  
24 the general practitioner; but it seems very unlikely that the  
25 legislature intended to discriminate against the podiatrist or

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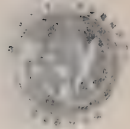




1 to confer a competitive advantage upon the physician. Certainly  
2 this ought not to be the case and I am sure that the medical  
3 practitioners themselves do not seek such an advantage and  
4 would not, in good faith, prefer to have it. In many instances,  
5 I suspect that the medical practitioner would prefer not to  
6 be burdened with treating matters properly within the scope  
7 of the podiatrist's practice. Notwithstanding this fact,  
8 however, the podiatrist as well as the physician are, in law,  
9 authorized to perform this service and it seems, to a lay  
10 observer, that they co-operate very admirably in serving the  
11 public interest in this regard.

12 In essence, the privilege of the selection of  
13 a practitioner is considered the right of every individual and  
14 this is qualified only to the extent that he must select a  
15 person who is, by law, entitled to perform the service he is  
16 seeking; with the Act in its present form, patients would be  
17 required in effect to pay twice for the services of a podiatrist.

18 Next, insurance premiums or prescriptions, such  
19 as the podiatrist's. There would seem to be no reason to  
20 suggest that the podiatrist's services not be covered by the  
21 proposed legislation and the only thought that we can see in  
22 this respect is the possibility of an added cost and our  
23 enquiries seem to indicate that such an objection is erroneous.  
24 We say: "The coverage of podiatric service would not incur  
25 added cost to the plan, as rates are based on benefits for



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however, the podiatrist as well as the physician, is  
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concern that they co-operate in the service of the public  
public interest is at stake.  
In essence, the question is whether the podiatrist  
a practitioner is considered the same as the physician  
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the Act in this regard is clear and unambiguous.  
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We say: "The coverage of podiatric services would not be  
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1 conditions and not who shall treat the conditions. This is  
2 substantiated by the fact that private insurance plans pro-  
3 viding payment for services rendered by podiatrists have not  
4 found it necessary to adjust rates nor have the rates of  
5 physician sponsored Blue Shield plans in the United States been  
6 adjusted when amended to cover the subscriber who elects  
7 medical or surgical treatment by a podiatrist." There is no  
8 actuarial evidence for the Commission in this regard. We did  
9 write to podiatric societies in the United States, various  
10 states, where their schemes were amended to provide for payment  
11 of podiatrists and these indicate that there was no adjustment  
12 in the rates charged as a result of the inclusion of their  
13 services. I may leave these with the Committee as well.

14 In addition, there are some 29, I believe,  
15 private insurance plans in the Province of Ontario which do  
16 at the moment cover and pay for services when rendered by a  
17 podiatrist. We have no information and no reason to believe  
18 that their rates were ever adjusted by the inclusion of payment  
19 of podiatrists.

20 In summary then, I make these points: (1) There is  
21 a demonstrated chronic need for specialized foot care; secondly  
22 that the podiatrist is extremely well qualified and, indeed,  
23 the only man who specializes in this field. The proposed  
24 legislation in this field does cover this type of service. In  
25 its present form, it would seem discriminatory in that the service



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1 if performed by a medical practitioners is covered, but not if  
2 performed by a podiatrist, even though he is qualified and  
3 legally entitled to perform such service. So there is no  
4 added cost and it would be both equitable and in the public  
5 interest that they be included. To give effect to this, we  
6 respectfully submit that the Bill should be amended to define  
7 the term "physician" to include a podiatrist. That is all I  
8 have to say.

9 THE CHAIRMAN: Thank you very much, Mr. Courey.  
10 Some of the members of the Enquiry have indicated their desire  
11 to ask questions of you.

12 DR. GALLOWAY: Mr. Courey, I imagine that some  
13 of the questions that I will want to ask you will deal primarily  
14 with the practice of podiatry and it may be that Dr. Tolbert  
15 will want to answer those questions. Are there any particular  
16 differences in this brief which you are presenting and the brief  
17 that will be presented in Toronto by the Society?

18 MR. COUREY: We felt that there was some  
19 different emphasis. Frankly, the brief was drawn and referred  
20 to them and so I think there is a very marked similarity  
21 between them. We did want to deal primarily with the right of  
22 the podiatrist in law to perform these services and on that  
23 basis his right to be included in a general plan by the payment  
24 of this particular type of service.

25 DR. GALLOWAY: This is the difference between the



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1 two briefs?

2 MR. COUREY: I think essentially it is no more  
3 than a matter of emphasis.

4 DR. TOLBERT: There is really no difference  
5 between the two briefs.

6 DR. GALLOWAY: How many podiatrists are there  
7 in Ontario and how many are there in this particular Society?

8 DR. TOLBERT: There are 68 podiatrists in  
9 Ontario; there are 6 in this Society.

10 DR. GALLOWAY: In the type of work that you do,  
11 a number of you do both office practice and some of you do  
12 hospital practice through clinics?

13 DR. TOLBERT: Yes.

14 DR. GALLOWAY: What would be the average work  
15 day as a podiatrist that you would have?

16 DR. TOLBERT: We spend about eight hours in our  
17 offices, I would say, and then there are house calls and calls  
18 of that type.

19 DR. GALLOWAY: Approximately how many people  
20 would you treat in a day?

21 DR. TOLBERT: I myself have been in practice  
22 two years. I would treat, on the average, fifteen patients a  
23 day. I would say the established practitioners would treat  
24 twenty, twenty-five patients a day.

25 DR. GALLOWAY: This would be a five-day week,



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1 as a rule?

2 DR. TOLBERT: Yes, as a rule.

3 DR. GALLOWAY: Somewhere then between roughly  
4 one hundred and one hundred and twenty-five patients a week?

5 DR. TOLBERT: That is right.

6 DR. GALLOWAY: And in a hospital, is this time  
7 taken out of your office practice or are you paid for that when  
8 you are in hospital?

9 DR. TOLBERT: In hospital here Dr. Ballard  
10 maintains a clinic at Riverview. He goes on Wednesday. He is  
11 paid. The exact number of patients he sees per Wednesday, I  
12 do not know. I did see one list that had about twenty patients  
13 on it.

14 DR. GALLOWAY: Would he be paid on a fee-for-  
15 service basis or a salary?

16 DR. TOLBERT: He is paid on a fee-for-service  
17 basis, by the Sunshine Fund set up by the Ladies' Auxiliary,  
18 I understand.

19 DR. GALLOWAY: Would you in your group, or your  
20 practice, be treating any indigent patients?

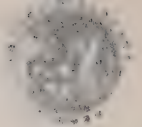
21 DR. TOLBERT: Pardon?

22 DR. GALLOWAY: Would you in your practice be  
23 treating any indigent patients?

24 DR. TOLBERT: Yes, we do.

25 MR. GALLOWAY: And on what basis, or how do you





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1 handle them?

2 DR. TOLBERT: The patient that obviously cannot  
3 pay at all, we just treat without fee. Those patients that  
4 have a problem, what I do, or what I think most practitioners  
5 do, is tell them what their fee is and tell them that when they  
6 can pay us, please do so.

7 DR. GALLOWAY: On reading through your brief,  
8 there are several things that come to my mind and maybe it is  
9 just a matter of wording. In the first sentence of paragraph  
10 one you have stated:

11 "Podiatry is the only area of medical practice  
12 which specializes in the treatment of foot  
13 disease."

14 In what sense are you using the wording "medical practice", and  
15 in what way do you define that the podiatrist is the only person  
16 specializing in foot disease? There are so many areas or so  
17 many other people in medicine who, at this moment, are interested  
18 in the feet.

19 DR. TOLBERT: I think we are talking about a  
20 total specialist. For instance, the dermatologist would never  
21 treat athlete's foot and he is a specialist in skin conditions.  
22 The orthopaedic surgeon is a specialist in bone and joint  
23 surgery and he would have an interest in the foot, from that  
24 point of view. But as a total area specialty, we are the only  
25 specialty. As far as medical practice is concerned, podiatry



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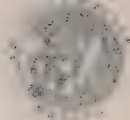
1 is a medical-surgical service and, therefore, we use the term  
2 "medical practice".

3 DR. GALLOWAY: Mr. Courey, on page 2, number 3,  
4 in which you have stated that:

5 "The privilege of selection of a practitioner  
6 is one that every individual accepts as his right;"  
7 and then there is the next phrase which says  
8 "...provided, however, that the practitioner he  
9 prefers is one entitled by law to perform or  
10 render the service needed."

11 Is that last phrase correct? Could the patient not elect to  
12 go to an unlicensed practitioner?

13 MR. COUREY: I suspect that he would be entitled  
14 to go to anyone for any service; but I think not, if he is  
15 called upon to use a public plan for the payment of those  
16 services. On the other hand, it is very difficult to say that  
17 he is even entitled to go to anyone for any service because in  
18 some instances such acts would constitute crimes. There are  
19 only certain individuals who are licensed to provide medical  
20 service or any type of professional service. Their limits  
21 are generally defined in law, so that people cannot render,  
22 unless they are licensed, a professional service. I think it  
23 would then be incorrect to say other than an individual is not  
24 entitled, under our system at least, to seek a professional  
25 service from a person who is not qualified to give it -- not if



is a medical-surgical service and, therefore, we use the term  
"medical practice"

DR. GALLOWAY: Mr. Courby, on page 2, number 3,

in which you have stated that:

"The privilege of selection of a practitioner  
is one that every individual accepts as his right  
and then there is the next phrase which says  
"...provided, however, that the practitioner be  
preferred is one entitled by law to perform or  
render the service needed."

Is that last phrase correct? Would the patient not want to  
go to an unlicensed practitioner?

MR. COURBY: I suggest that he would be entitled  
to go to anyone for any service; but I think not, if he is  
called upon to use a public plan for the payment of those  
services. On the other hand, it is very difficult to say what  
is even entitled to go to anyone for any service because in  
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service from a person who is not qualified to give it -- not if



1 he is going to be paying for it, and certainly not if he is  
2 going to use a public plan to finance it.

3 DR. GALLOWAY: This is only true if you are  
4 speaking of it in regard to medical health insurance, as I  
5 think you are in this brief?

6 MR. COUREY: Yes.

7 DR. GALLOWAY: I was interested in the fact that you  
8 do not think that costs would rise. I wonder if we can ask  
9 the Doctor what percentage of your patients pay you in cash  
10 and receive reimbursement from the insurance company and what  
11 percentage do you think are insured at the present time?

12 DR. TOLBERT: I would say 95% of my patients  
13 are covered by health insurance, the Windsor Medical Services.  
14 Windsor Medical Services is a physician-sponsored plan. It  
15 does not reimburse them for them podiatric services; therefore,  
16 the patients who do pay me -- and it is about 90% -- do pay me  
17 in cash. Some people do have private insurance plans along  
18 with it. I have not had one private insurance plan that would  
19 not reimburse them.

20 DR. GALLOWAY: If you do have six practitioners  
21 treating one hundred people a week, which means about six  
22 hundred treatments, what rates do podiatrists charge?

23 DR. TOLBERT: The fee schedules vary from area  
24 to area. An Ontario office call is five dollars. A house call  
25 is seven dollars. A hospital call is seven or five. The





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11 percentage do you think the insured are prepared to pay

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1 surgical fees vary with the services.

2 DR. GALLOWAY: This means quite a sum of money  
3 that must be found someplace?

4 DR. TOLBERT: It can be quite a burden for some  
5 patients and it is.

6 DR. GALLOWAY: It also could become quite a  
7 burden to a health insurance plan.

8 MR. COUREY: We have tried, as best we can, to  
9 determine whether or not the rates would increase. Now, I  
10 do not understand the ramifications of this, but I would think  
11 that a patient, if covered by insurance, would be somewhat  
12 wont to seek attention from a person, even although he might  
13 be qualified and entitled to perform that service, if it meant  
14 the paying, in addition to his service, a fee to that particu-  
15 lar practitioner. In other words, you can't help but draw the  
16 conclusion that these people must seek assistance from persons  
17 who are covered to do so. In many cases this might be the  
18 doctors in this area, particularly where Windsor Medical is  
19 the prevailing insurance program. I do not know that the  
20 service which the podiatrist performs takes in any area of  
21 practice that is not performed by a doctor or medical practi-  
22 tioner. If it is necessary and the patient consults him, I  
23 should think that that is precisely where the medical practi-  
24 tioner would handle it. What would happen then is that the  
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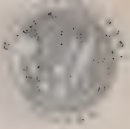
1 or to pay twice. By including podiatrists, the rates have not  
2 increased in a number of other jurisdictions, even physician-  
3 sponsored plans, which have included them in it. It can only  
4 be assumed that this comes about by a change of the practitioner  
5 dealing with the service. Some patients, and I suspect to the  
6 annoyance of some physicians and to the pleasure of many others,  
7 seek this service from a podiatrist but to the insurance  
8 company I do not think it makes any difference, if they have  
9 to pay for this service, regardless of who they pay.

10 DR. GALLOWAY: Do you think there would be any  
11 greater utilization of the service if it was insured under a  
12 medical health insurance plan?

13 DR. TOLBERT: I think probably there would be,  
14 as there has been with all comprehensive insurance plans, such  
15 as in Windsor with the Windsor Medical Services. The only  
16 thing is I think we would see less of chronic cases and more  
17 acute cases and, therefore, treatment periods would actually  
18 decline.

19 DR. GALLOWAY: In your hospital practice, do you  
20 work as a practising podiatrist or do you work under the  
21 direction of some medical person?

22 DR. TOLBERT: In the clinic at Riverview  
23 Hospital, it has a podiatric clinic and it is just under the  
24 general direction of the staff, as all other plans are. When  
25 I go into a general hospital to treat a patient, it is always at



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I go into a general hospital to treat a patient, it is always



1 the request of a physician and I never do anything that I have  
2 not consulted with him about.

3 DR. GALLOWAY: Thank you very much, Mr. Courey  
4 and Dr. Tolbert. I am sure there will be many other questions  
5 that will come up. But you have helped me a great deal.

6 DR. HAMILTON: Mr. Courey, in item 6 on page 2,  
7 I am not quite clear what is meant at the bottom of the page:

8 "'physician' means a medical practitioner  
9 registered as such under The Medical Act...",  
10 and the next part is what I do not understand --

11 "or under the comparable legislation of any  
12 jurisdiction outside Ontario in which medical  
13 or surgical care or services are rendered to a  
14 resident, ..."

15 MR. COUREY: I do not understand that either,  
16 but it was in Bill 163 in that manner and I did not wish to  
17 alter it in that section. I only wished to include podiatrists.

18 DR. HAMILTON: The second part of this, which  
19 states "...and for the purpose of this Act" -- you mean Bill  
20 163, presumably -- "the term 'physician' shall include a  
21 podiatrist.." Do you mean that there shall be two definitions  
22 of physician, one under the Medical Act and one under Bill 163?

23 MR. COUREY: No. For the purposes of this  
24 legislation, a podiatrist acting within the scope of his practice,  
25 would be entitled to the benefits which accrue to medical





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1 practitioners or physicians acting within the scope of their  
2 practice. It would seem to be the simplest and most clear way.  
3 I refer to the more skilled draftsman to deal with this point.  
4 Within the scope of their practice, if this service is to  
5 be covered, this is on an equitable basis of persons entitled  
6 to perform this service and qualified to perform it, and these  
7 people are very well qualified. I find myself somewhat  
8 surprised at the qualifications. But they should be entitled  
9 to be included and the Act is discriminatory to exclude this  
10 service if performed by another person who, by law, is entitled  
11 to perform it. It should cover the service and not a single  
12 profession.

13 DR. HAMILTON: I have one last question. Where  
14 are the faculties of podiatry?

15 MR. COUREY: There are two: The California  
16 Podiatric College and the Ohio College of Podiatry. There is  
17 also the St. Luke's, a children's medical centre, the College  
18 of Podiatry, the Illinois College of Podiatry and I believe  
19 there is one in New York. There are five in the United States.

20 DR. HAMILTON: Have all of these university  
21 affiliation or sponsorship?

22 MR. COUREY: I believe not. I think many of  
23 them started with and are now separate teaching institutions.  
24 I do not know that they even all started with -- but they are  
25 not today all affiliated with universities.

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them started with and are now separate teaching institutions.

I do not know that they even all started with -- but they are

not today all affiliated with universities.





1 DR. HAMILTON: Are any of them affiliated with  
2 universities?

3 DR. TOLBERT: Not at the present time, no.

4 MR. CASWELL: Mr. Courey, you are really not  
5 seriously concerned with having Bill 163 amended to call a  
6 podiatrist a physician? I assume what you are interested in  
7 is having podiatric services included as far as benefits go  
8 under Bill 163?

9 MR. COUREY: Yes, and included if performed by  
10 a podiatrist.

11 MR. CASWELL: In the summary you are suggesting  
12 that the Act would be changed so that the podiatrist actually  
13 would be called a physician; but you are not really concerned  
14 with that, are you?

15 MR. COUREY: No, sir.

16 DR. TOLBERT: There is one thing on that. The  
17 reason we chose this wording, and it was largely at Mr. Courey's  
18 suggestion, was because this is the wording in the Blue Shield  
19 Plans in the United States where they define a physician and  
20 then they say: "Within his scope of practice, a podiatrist  
21 shall be considered a physician for the services covered under  
22 this contract."

23 MR. WHITNEY: Of course, that is a contract and  
24 not a legislative bill?

25 DR. TOLBERT: That is correct.



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MR. COURCY: Yes, and included if performed by a podiatrist.

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MR. WHITNEY: Of course, that is a contract and not a legislative bill?



1 MR. COUREY: I pointed out, from the draftsman's  
2 point of view, you will have difficulty in dealing with it in  
3 any other way, but we do not object to dealing with it in any  
4 other way.

5 DR. TOLBERT: We are not trying to be called  
6 "physicians".

7 MR. CASWELL: What you actually want is to have  
8 your services included in the Act. It would seem very difficult  
9 to recommend that the podiatrist should be called a physician.

10 MR. COUREY: I will leave it with that, except  
11 I certainly did not intend that and only where the term is used  
12 in this Act, he shall be included, if acting within the scope  
13 of his practice.

14 THE CHAIRMAN: Mr. Major?

15 MR. MAJOR: I have no questions, Mr. Chairman.

16 THE CHAIRMAN: Miss McArthur?

17 MISS McARTHUR: I understood that the delegation  
18 was tabling the basis on which the opinion that the objection  
19 of rising costs was based. They are going to table the  
20 documents on which they base what appears to be an opinion on  
21 this, on page 2 section 4. Am I correct, you are leaving the  
22 basis on which this is based?

23 MR. COUREY: I will leave letters indicating  
24 that -- and this is all we have -- that the rates have not  
25 increased.





MR. COUNRY: I pointed out, from the draughtsman's point of view, you will have difficulty in dealing with it in any other way, but we do not object to dealing with it in any other way.

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MR. COUNRY: I will leave it with that, except I certainly did not intend that and only where the term is used in this Act we have no objection to its use in his practice.

THE CHAIRMAN: Mr. Mayor.

MR. MAJOR: I have no questions, Mr. Chairman.

THE CHAIRMAN: Miss McArthur?

MISS McARTHUR: I understood that the objection was tabling the basis on which the objection of raising costs was based. They are going to table the documents on which they base what appears to be an opinion on this, on page 2 section 4. And I correct, you are leaving the basis on which this is based.

MR. COUNRY: I will leave letters indicating

that -- and this is all we have -- that the rates have not increased.



1 THE CHAIRMAN: Are there any other members who  
2 have questions?

3 MR. WHITNEY: Mr. Courey, we have referred to  
4 the insurance coverages in the United States. There was very  
5 little reference to Canadian coverages. In your research, do  
6 you find podiatric treatment covered by the carriers or the  
7 insurers in Canada?

8 MR. COUREY: Yes. There is an appendix to the  
9 brief which we submitted and I can leave, again, with you a  
10 list of 29 companies in Ontario.

11 MR. WHITNEY: I remember that now.

12 THE CHAIRMAN: Are there any further questions?

13 MR. MULROONEY: On page 5, paragraph 5, you  
14 speak of treatment rendered by podiatrists in certain teaching  
15 hospitals in Toronto: St. Joseph's, Toronto Western, St.  
16 Michael's, Toronto General and Baycrest. Are podiatrists  
17 authorized to have patients admitted to those hospitals?

18 DR. TOLBERT: These are out-patients clinics.  
19 We do not have in-patient privileges.

20 MR. MULROONEY: Could you be more specific about  
21 the type of treatment that is rendered in these clinics; just  
22 what is done by the podiatrist?

23 DR. TOLBERT: In most of them -- in fact in all  
24 of them, it is the treatment of skin lesions, particularly in  
25 diabetic patients, because they have found that with the treatment



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MR. MURKIN: On page 5, paragraph 5, you speak of treatment rendered by podiatrists in certain teaching hospitals in Toronto: St. Joseph's, Toronto Western, St. Michael's, Toronto General and Baycrest. Are podiatrists authorized to have patients admitted to those hospitals? DR. TORRENT: There are out-patient clinics. We do not have in-patient facilities.

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DR. TORRENT: In most of them -- in fact in all of them, it is the treatment of skin lesions, particularly in diabetic patients, because they have found that with the treat-





1 of these lesions we have prevented ulcerations, gangrene, and  
2 amputations. I understand that minor surgery for nails and  
3 for corns is also being done on an out-patient basis in at  
4 least one of these hospitals.

5 MR. MULROONEY: In your treatment, do you ad-  
6 minister anaesthetics?

7 DR. TOLBERT: Yes, locally.

8 MR. MULROONEY: Local anaesthetics?

9 DR. TOLBERT: Yes.

10 MR. MULROONEY: Cocaine and that sort of thing?

11 DR. TOLBERT: Yes.

12 MR. MULROONEY: Thank you, Mr. Chairman.

13 THE CHAIRMAN: Are there any further questions?  
14 Thank you, gentlemen.

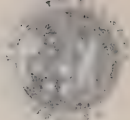
15 Are the members of the delegation from the  
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18 SUBMISSION OF  
19 THE KENT COUNTY MEDICAL SOCIETY

20 .Appearances: Dr. A. C. Henderson  
21 Dr. L. J. Shepley  
22 Dr. J. S. Packham

23 THE CHAIRMAN: Were the members of this delega-  
24 tion present when I read the instructions to the previous  
25 elegation?

DR. SHEPLEY: Yes.



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1 THE CHAIRMAN: Under those circumstances, I  
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3 DR. SHEPLEY: Mr. Chairman and Members of the  
4 Enquiry: In presenting this brief from the Kent County Medical  
5 Society, we do so because we have the feeling that we have had  
6 a rather unique experience for the past quite a number of years  
7 in that our County has been privileged to share in the develop-  
8 ment of Windsor Medical Services because very early after its  
9 development here in Windsor we became a branch society or a  
10 branch of the Windsor Medical Services. This has enabled us,  
11 over the years, to have experience with this service type of  
12 plan and, at the same time, we have had the opportunity to  
13 witness and experience the application of many other types of  
14 insurances applicable to medical care. We have had a sub-  
15 stantial number who have, over the years, used the services of  
16 the Physicians' Services Incorporated in its development. There  
17 have been a number who have had Associated Medical Services  
18 coverage and, in more recent years, we have been very pleased  
19 to see develop the service type of coverage provided through  
20 the Kent Medical Co-Operative. During this time it has also  
21 been possible for us to extend the application of the indemnity  
22 type of insurance coverage so that we feel we have had an  
23 opportunity, perhaps, more unique in this area than in any other  
24 part of the province, to see all these types of insurances  
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1 experience and our recommendations, which we have listed in  
2 our brief, which we feel is a very brief brief, are detailed  
3 there in order.

4 We would like to emphasize the fact that our  
5 brief is not presented with any idea of being in opposition to  
6 the brief which would be presented by our parent organization,  
7 the Ontario Medical Association, but would be presented to  
8 emphasize such aspects of the problems as may be presented in  
9 the Association brief and, perhaps, to bring a little different  
10 slant on some of the aspects.

11 Primarily, we have come to feel that the  
12 coverage should be based primarily on a service type plan.  
13 This has come to be the feeling of physicians who are members  
14 of our Kent County Medical Society and I do not feel we need  
15 to elaborate too much on our reasons for it, except that we  
16 have, in our opinion, found that it seems to satisfy the needs  
17 of our patients and the needs of the attending physicians in  
18 the best way.

19 Now, as a sort of basic philosophy, we have  
20 developed the idea that in the provision of medical services  
21 by insurance, the financial gain by a corporation or carrier  
22 providing this arrangement should not be a motivating factor.  
23 This is a philosophy which we have evolved, after watching the  
24 experience of both our patients and our own profession, in  
25 conjunction with the application of the various types of medical



experience and our recommendations, which we have listed in  
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1 insurance plans.

2 Now, these are perhaps the chief recommendations  
3 that we would like to present for the consideration of the  
4 Enquiry. We have some more or less specific suggestions. We  
5 do believe that the coverage should be comprehensive and that  
6 Schedule B proposed in Bill 163 be deleted. We have several  
7 reasons for that, which are listed. But, primarily, we feel  
8 that our experience has indicated that, by and large, there  
9 are very few people who, in the long run, prefer to have this  
10 type of in-hospital only coverage. We have a feeling that the  
11 inclusion in the legislation of this may just simply be a bit  
12 of cluttering up of the provision of service which we visualize  
13 as being the intent of this legislation.

14 We have come to feel, on this basis that we have  
15 enunciated, that the premium structure should be community  
16 rated rather than experience rated and I guess that sort of  
17 ties in with our idea that the service plan type of coverage  
18 is what we prefer.

19 We have suggested that there be a three rate  
20 premium structure which, I believe there are many others feel  
21 should exist, and we have suggested certain specific changes  
22 in the Act, which need not be elaborated on.

23 We have also heard a good deal of discussion  
24 relative to the proposal of pooling and it seems to be inferred  
25 in the Bill, and in discussion relative to it, that some type

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We have come to feel, on this basis that we have announced, that the premium structure should be community rated rather than experience rated and I guess that sort of ties in with our idea that the service plan type of coverage should exist, and we have suggested certain specific changes in the Act, which need not be elaborated on.

We have also heard a good deal of discussion relative to the proposal of pooling and it seems to be inferred in the Bill, and in discussion relative to it, that some type



1 of pooling mechanism which will help to share the costs of the  
2 high-cost patient will become mandatory or necessary in some  
3 way. We have felt that rather than basing such a pooling  
4 mechanism on the idea of originally assessing the individual  
5 by previous experience as to whether or not they would be a  
6 high-cost case or group, and then putting them in the pool,  
7 ahead of actual experience, that pooling can be accomplished  
8 very satisfactorily by the carriers pooling after experience,  
9 after-experience pooling.

10 We feel that can be a way which would equalize  
11 the sharing of the high-cost patients -- and I use the word  
12 patients because, after all, it is the individual who counts.  
13 We have evolved the actual arithmetical solution for this, which  
14 may seem much too simple for the actuaries who might have to  
15 actually put it into practice, but we believe, from our  
16 experience with management in so many parts of our economy,  
17 that management often can be asked to do what seems to be the  
18 impossible and they come up with an answer. We think that in  
19 actual practice applying the principle of a community rated  
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21 assessing such accounts as may be worked out,



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2 carriers can be summed, and that this corporation, Medical  
3 Carriers Incorporated, that is suggested, could be the agent  
4 for accumulating these details and assessing them. Then each  
5 individual carrier would have its own average cost, its own  
6 total cost, and the average cost in a given carrier's  
7 experience would vary according to the number of high-cost  
8 cases that they might have to actually pay medical bills for.  
9 In others the number, or the proportion of the  
10 high-cost cases might be so significantly small that it would  
11 appear to be a profit, but actually it would mean that the  
12 carriers who had experienced a loss could bill their debits,  
13 their loss, to the pool, and the carriers who had experienced  
14 a profit could credit their profit to the pool, and then the  
15 funds would be distributed in such a way that each one's total  
16 cost would be covered.

17 I may have made this appear too simple, and  
18 there may be many questions which would be applicable, but we  
19 are of the opinion that any pooling on a pre-experience basis  
20 could not but ultimately force all the carriers toward what we  
21 have suggested. We might just as well start that at the start,  
22 and that's a community-rated premium structure.

23 I think that's all I have to say, thank you,  
24 Mr. Chairman.

25 THE CHAIRMAN: Some of the members of the

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I think that's all I have to say, thank you.

Mr. Chairman.

THE CHAIRMAN: Some of the members of the





1 Enquiry will want to ask you questions. Miss McArthur?

2 MISS McARTHUR: I have a very simple one,  
3 although it was a question of definition.

4 We notice you have a similar discussion, No. 16  
5 on the last page, to one which will be presented this after-  
6 noon. Since this Item 6 under Schedule A suggests that newborn  
7 infants might be exempted, we would like to have your opinion  
8 as to why you suggest that this be not included, and I think  
9 some of the members of the Committee would be interested in  
10 your definition of a newborn infant.

11 DR. SHEPLEY: Mr. Chairman and members of the  
12 Enquiry: we felt that this didn't quite clarify what might be  
13 understood in one area, and in other areas another understand-  
14 ing might arise, and so, when you say newborn-infant care,  
15 we couldn't just feel that that was clear enough to really  
16 have satisfactory meaning, because it might mean in somebody's  
17 idea just the in-hospital well-baby care, performed by any  
18 physicians, or it might mean the care of a new baby, who is  
19 sick during its time shortly following birth, or it might be  
20 interpreted to mean the care of the newborn for weeks or  
21 months, and specifically also we felt that this might be  
22 interpreted to mean that if an obstetrician delivered the  
23 baby, and he turned the care of the baby over to a paediatrici-  
24 cian, that the paediatrician might be entitled to make a  
25 charge for the newborn care, whereas the physician who

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20 interpreted to mean the care of the newborn for weeks or

21 months, and specifically also we felt that this might be

22 interpreted to mean that if an obstetrician delivered the

23 baby, and he turned the care of the baby over to a pediatric-

24 ian, that the pediatrician might be entitled to make a

25 charge for the newborn care, whereas the physician who



1 delivered the baby would not be able to make a charge for new-  
2 born care, whether it was ill or well.

3 We felt that it would be better to leave this  
4 right out, and it could be an item which could be better  
5 arranged for through the Ontario Medical Association's tariff,  
6 so that if the time were to arrive when the obstetrical fee  
7 should not include the in-hospital immediately post-delivery  
8 newborn baby care by the attending physician, it could be so  
9 spelled out in the tariff, and to include it specifically in  
10 legislation ties the hand of anyone who might subsequently be  
11 performing the newborn infant care, it being a problem if such  
12 a baby were delivered and there was nobody else to deliver it,  
13 and he chose to look after it himself.

14 MISS McARTHUR: That's a few reasons.

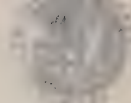
15 MR. CASWELL: Doctor, you tell us, or it's my  
16 understanding, that the Kent County Medical Society is  
17 composed of doctors who are practising in the county.

18 Is there some restriction on a practising doctor  
19 becoming a member of the Kent County Medical Society?

20 DR. SHEPLEY: No, it's a voluntary membership.  
21 The members of the Society are those who voluntarily band  
22 together to form the Kent County Branch of the Ontario Medical  
23 Association.

24 MR. CASWELL: I'm asking this because it would  
25 appear from your brief, and from the information that we have,





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1 that this service has been reasonably satisfactory, so I find  
2 it difficult to understand why 25% of your practising doctors  
3 would not be associated with your Society.

4 This seems to be a fairly high percentage of the  
5 doctors practising in the county who would belong if there was  
6 not something wrong somewhere. You say four honorary members,  
7 and you have 70 out of 84 who are practising members belonging  
8 to your Society, so in other words, you have 20% that do not  
9 belong. You've got 70 active, you say, and you have 14 prac-  
10 tising doctors who don't belong?

11 DR. SHEPLEY: Four are honorary members.

12 MR. CASWELL: Well, I'm not counting them.

13 DR. SHEPLEY: The honorary members also practise.

14 MR. CASWELL: Oh, well, I assumed that they  
15 didn't practise.

16 DR. SHEPLEY: They are honorary members awarded  
17 honorary membership in our Society because of long standing,  
18 very fine association with our profession.

19 MR. CASWELL: Well you still have ten who do  
20 not belong for some reason or other.

21 DR. SHEPLEY: Yes.

22 MR. CASWELL: You are suggesting, in No. 6 on  
23 page 6, that the physician and his patient are interested, not  
24 in sound underwriting, but rather in giving and receiving  
25 medical care, and it would seem to me that both the patient



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1 and the physician have to be interested in sound underwriting,  
2 whether this service is going to be paid for by the employer  
3 and the employee, or by the patient and the Government, or by  
4 the Government itself. Ultimately, the patient and the tax-  
5 payer is going to be paying for it, and unless he is interested  
6 in the underwriting of the scheme, it isn't going to be very  
7 practical, I think.

8 DR. SHEPLEY: I think that it is most important  
9 that one read this in context. We feel that basically the  
10 physician and his patient are not interested in the insurance  
11 underwriting principle so that a profit can be made. We are  
12 interested in sound underwriting so that the arrangements can  
13 be made so that both the giving and receiving of medical care,  
14 if needed, can be arranged for, and that it can be paid for.

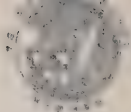
15 The important phrase there is:

16 "...so that a profit can be made..."

17 We, as I said before in my introductory remarks,  
18 do feel that the profit motive should not be an impelling  
19 aspect of the development of medical insurance.

20 MR. CASWELL: Of course, this is going to be  
21 controlled by the competitive nature of the carrier service.  
22 It's going to be a minimum rate, and a competitive service.  
23 It's not going to be given by one carrier, and that, to a  
24 large degree, is going to control the profit ratio.

25 DR. SHEPLEY: We are interested in sound



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23 large degree, is going to control the profit ratio.  
24 DR. SHEPHELY: We are interested in sound



1 underwriting, but not so that a profit can be made by a carrier.

2 Does that explain our position?

3 MR. CASWELL: Yes, I know exactly what you are  
4 saying, but I don't think that you, as a physician, or I, as a  
5 patient, can expect that a carrier is going to provide the  
6 service without a reasonable profit. I don't think that's  
7 fair to expect.

8 THE CHAIRMAN: I think that Dr. Shepley has  
9 registered his point, and we don't want to debate it.

10 DR. HAMILTON: Dr. Shepley, there's just one  
11 question I have to ask. It's under Item 5 in your recommenda-  
12 tions:

13 "That the totally subsidized should be  
14 covered by an extended Medical Welfare  
15 Plan."

16 Would you please tell me why you make that  
17 recommendation?

18 DR. SHEPLEY: We believe that if the state is  
19 entering into arrangements for the provision of opportunities  
20 for people to have their medical services covered, the cost of  
21 their medical services covered, that those who are medically  
22 indigent, totally subsidized, shouldn't be in the position  
23 that when they are admitted to hospital they should there  
24 find themselves in a different position, that they, as they  
25 have now, should have their medical welfare coverage, as





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1 through our Medical Welfare Plan, the Ontario Medical Associa-  
2 tion's through the Department of Welfare, and by extending  
3 their benefits to include those of the comprehensive plan in  
4 hospital, as well as out of hospital, the individuals then  
5 have their medical coverage as private patients both in and  
6 out of hospital.

7 I'm very keenly aware of the problems concerning  
8 the teaching hospitals.

9 DR. HAMILTON: That was really not relevant to  
10 my question, Dr. Shepley. My question was really directed  
11 towards finding out if you meant by this that the indigent  
12 patients should continue to be treated under the Welfare Plan  
13 as presently operated by the Ontario Medical Association?

14 DR. SHEPLEY: I do.

15 DR. HAMILTON: They would have no choice in  
16 regards to their insurance, but they would receive the same  
17 benefits, meaning then that the Ontario Medical Association  
18 would be operating as an insurance carrier.

19 Is that what you mean? They would then be in  
20 competition with the insurance companies providing coverage  
21 under the Act?

22 DR. SHEPLEY: It's our feeling that the Govern-  
23 ment felt an obligation for the provision of medical  
24 care to the totally indigent,  
25 and that over the years this has been done out of hospital

through our Medical Welfare Plan, the Ontario Medical Association's through the Department of Welfare, and by extending their benefits to include those of the comprehensive plan in hospital, as well as out of hospital, the individuals then have their medical coverage as private patients both in and out of hospital.

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1 through its association between the Department of Welfare and  
2 the Ontario Medical Association, and that we here in Kent have  
3 felt that this has worked very well. We have been under the  
4 impression that it has provided an opportunity for the indigent  
5 patient to receive medical care, and at the same time the physi-  
6 cian to be compensated through the Medical Welfare Plan which  
7 is our professionally-administered arm, so to speak, of the  
8 Department of Welfare, a department of government,  
9 and we just felt that where government was endeavouring to  
10 extend the care it may well extend the benefits in its Medical  
11 Welfare Plan.

12 We believe that the Medical Welfare plan should  
13 be continued as the means for the provision, through the Depart-  
14 ment of Welfare, in conjunction with the Ontario Medical Asso-  
15 ciation, of care of the totally medically indigent.

16 DR. HAMILTON: But the same benefits would be  
17 available to the individuals in the Medical Welfare Plan as  
18 those who purchase their insurance plan from some other agency;  
19 is this what you mean?

20 DR. SHEPLEY: Yes.

21 DR. HAMILTON: Thank you very much.

22 DR. GALLOWAY: I would like to go one step  
23 further, and ask a question of the doctors, whether or not  
24 their interest is in the patients receiving the care and that  
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DR. HAMILTON: Thank you very much.

DR. GALLOWAY: I would like to go one step further, and ask a question of the doctors, whether or not their interest is in the patients receiving the care and that the doctors receive payment for the care.



1                   What would be the advantage of the Ontario  
2 Medical Welfare Plan           over some other institution taking  
3 over the administration of this, if this was let out on a  
4 tender, for example, to one of the major insurance companies,  
5 would you have any objection to this?

6                   DR. SHEPLEY: Mr. Chairman, we've felt that  
7 experience is a great teacher, and the experience, we believe,  
8 of the Department of Welfare and our Association have been  
9 extremely satisfactory in the provision of the arrangements  
10 for the medical services to the indigents out of hospital,  
11 and for the payment for these services by government through  
12 the Medical Welfare Plan, and we visualize that this could  
13 very well be a means by which government could, on its behalf,  
14 most satisfactorily arrange for the extension of the coverage  
15 to the in-hospital care of the medically indigent people.

16                   You ask what my opinion would be if they were to  
17 sell it out to another carrier. I wouldn't like to see that  
18 happen myself, personally. I believe the members of our  
19 Society have felt sincerely that the present Medical Welfare  
20 Plan has worked so appropriately that we could visualize it  
21 continuing to operate appropriately just by extending the bene-  
22 fits.

23                   MR. NAYLOR: Dr. Shepley, you have recommended  
24 the service type of plan, on the basis of what you have seen  
25 of the operation of service-type plans, and indemnity plans,



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Plan has worked so appropriately that we could visualize it

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fits.

MR. MAYLOR: Dr. Shepley, you have recommended

the service type of plan, on the basis of what you have seen

of the operation of service-type plans, and indemnity plans,



1 side by side.

2 I wonder if, perhaps, you have reached that  
3 conclusion because, perhaps, in many cases, a service-type  
4 plan is paying the full costs, whereas the indemnity-type  
5 plan, in many cases, might be something less than the current  
6 scale of fees, and if we had an indemnity type of plan which  
7 paid the full current scale of medical fees, would you then  
8 still feel that there was any reason for preferring a service-  
9 type plan?

10 DR. SHEPLEY: Mr. Chairman, our experience has  
11 been in our county where we have had the opportunity to see a  
12 substantial number of people with service plans, and more  
13 recently people with indemnity plans, and to practise medicine  
14 in that set-up, that we came to the conclusion that people  
15 like the service plan way of coverage better, and we like it  
16 better.

17 I don't feel that the actual failure of the  
18 indemnity type of plan to cover the total fee was the primary  
19 factor in making the decision. The position was more one of  
20 ease, and the type of arrangement whereby the patient had  
21 really no forms to be taken to the doctor, and no dealings,  
22 other than just paying his premium to the carrier.

23 The whole thing seems to work more than satis-  
24 factorily on the basis of the plain service type of coverage,  
25 and if we get back to the basic philosophy, which we are



I wonder if, perhaps, you have reached that conclusion because, perhaps, in many cases, a service-type plan is paying the full costs, whereas the indemnity-type plan, in many cases, might be something less than the current scale of fees, and if we had an indemnity type of plan which paid the full current scale of medical fees, would you then still feel that there was any reason for preferring a service-type plan?

DR. SHELLY: Mr. Chairman, our experience has been in our county where we have had the opportunity to see a substantial number of people with service plans, and more recently people with indemnity plans, and to practice medicine in that set-up, that we came to the conclusion that people like the service plan way of coverage better, and we like it better.

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The whole thing seems to work more than satisfactorily on the basis of the plain service type of coverage, and if we get back to the basic philosophy, which we are





1 somewhat steeped in here, I believe that was evolved when  
2 Windsor Medical began this service type of insurance.

3 MR. NAYLOR: Thank you, Dr. Shepley. You have  
4 suggested that a community rate system should be used, and also  
5 a simple pooling method, which, as I understand it, would seem  
6 to involve all the insurance being put into the one big pool  
7 also. It does seem to me that that kind of a pooling arrange-  
8 ment would work out equitably only if all carriers charged  
9 exactly the same premium rates, and I wonder, therefore, if I  
10 understand your suggestions correctly, as it seems to me they  
11 would involve the regulation of premium rates to the point  
12 that all carriers would charge uniform rates, and all competi-  
13 tion would be removed.

14 Is that what you mean by your proposals?

3 15 DR. SHEPLEY: Ostensibly it comes down to the  
16 belief that the premium charged for the plan provided by a  
17 regulation under the Act would be the same charge by all corpo-  
18 rations, all carriers, and I think we feel that it would ulti-  
19 mately come to that after experience.

20 DR. BUTT: My first question had to do with the  
21 interpretation of pooling, as opposed to reimbursement, or  
22 opposed to re-distribution after a certain length of time.

23 I presume that after one year, whether you are  
24 forecasting or not, you are basing it on the statistics, so  
25 that you have your statistics on which the actuarial pooling

Windsor Medical began this service type of insurance.

MR. MAYLOR: Thank you, Dr. Shepley. You have

suggested that a community rate system should be used, and also a simple pooling method, which, as I understand it, would seem to involve all the insurance being put into the one big pool also. It does seem to me that that kind of a pooling arrangement would work out admirably only if all carriers charged exactly the same premium rates, and I wonder, therefore, if I understand your suggestions correctly, as it seems to me they would involve the regulation of premium rates to the point that all carriers would charge uniform rates, and all competition would be removed.

Is that what you mean by your proposal?

DR. SHEPLEY: Obviously it comes down to the

belief that the premium charged for the plan provided by a regulation under the Act would be the same charge by all corporations, all carriers, and I think we feel that it would naturally come to that after experience.

DR. BUTT: My first question had to do with the

interpretation of pooling, as opposed to reimbursement, or opposed to re-distribution after a certain length of time. I presume that after one year, whether you are forecasting or not, you are basing it on the statistics, so that you have your statistics on which the actual pooling



1 would be carried out.

2 The other thing is you do feel that the pooling  
3 is, shall I say, something satisfactory, and something worth-  
4 while; is that correct?

5 DR. SHEPLEY: Prefacing our reply on the philo-  
6 sophy that it's post-experience, not pre-experience, rate.

7 Pre-experience rating picks out a group, I  
8 understand, and says, "These are in experience a high-cost  
9 group, so we must put them in the pool," whereas actual  
10 experience would make it possible to determine the exact costs  
11 of the high-cost groups of people.

12 DR. BUTT: I think you're saying the same thing.  
13 After one year's experience either way?

14 DR. SHEPLEY: Yes.

15 DR. BUTT: You dealt with the Medical Welfare  
16 Plan, and I'm not quite sure whether you answered Dr.  
17 Hamilton's question; namely, could anybody else handle it?

18 The other point that I wanted to ask you was,  
19 do you realize how the Medical Welfare Plan, or can you tell  
20 me, receives their payments for premiums, or in lieu of premiums,  
21 and how it is distributed to the physician? Can you give me  
22 your interpretation of this, and whether this would change the  
23 situation, or whether the situation would be changed by this  
24 Act if the premiums were paid?

25 DR. SHEPLEY: Mr. Chairman, Dr. Butt is very



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situation, or whether the situation would be changed by this

Act if the premiums were paid?

DR. SHEPHERD: Mr. Chairman, Mr. Butt is very



1 cognizant of the way in which the Medical Welfare Plan  
2 derives its funds by the Ontario Medical Association negotia-  
3 ting with the Department of Welfare, and arranging for a per  
4 capita contribution, a per indigent, to the medical Welfare  
5 Plan per month, and on that basis there's so much money put  
6 into the fund, and then this is distributed by the Medical  
7 Welfare Plan to the physicians who render the service, and  
8 the distribution is based on the tariff of the Ontario Medical  
9 Association, but not necessarily has it been possible to make  
10 full payment for the services on a hundred per cent of this  
11 tariff. This has been pro-rated as experience necessitated  
12 according to the amount of money which has become available in  
13 this Medical Welfare Plan, and one can certainly see the possi-  
14 bility that such a - you can call it premium or per capita  
15 contribution, could not be negotiated at such a level as  
16 would make it feasible for the profession to continue to  
17 participate in the Medical Welfare Plan, and yet we have felt  
18 over the years that experience has been such that the Associa-  
19 tion has been able to negotiate in a very friendly manner with  
20 government, and come up with something that was quite  
21 reasonable.

22 DR. BUTT: My question, specifically, I think,  
23 was that if the benefits are equal to any other Schedule A  
24 which you suggest, and the premiums are changed for that, does  
25 this change your thinking?

cognizant of the way in which the Medical Welfare Plan derives its funds by the Ontario Medical Association negotiating with the Department of Welfare, and arranging for a per capita contribution, a per indigent, to the medical welfare Plan per month, and on that basis there's no much money put into the fund, and then this is distributed by the Medical Welfare Plan to the physicians who render the services, and the distribution is based on the tariff of the Ontario Medical Association, but not necessarily has it been possible to make full payment for the services on a hundred per cent of this tariff. This has been pro-rated as experience necessitated according to the amount of money which has become available in this Medical Welfare Plan, and one can certainly see the possibility that such a - you can call it premium or per capita contribution, could not be negotiated at such a level as would make it feasible for the profession to continue to participate in the Medical Welfare Plan, and yet we have felt over the years that experience has been such that the Association has been able to negotiate in a very friendly manner with government, and come up with something that was quite

DR. BURT: My question, specifically, I think,

was that if the benefits are equal to any other Schedule A which you suggest, and the premiums are charged for that, does this change your thinking?





1 DR. SHEPLEY: It doesn't change my thinking.

2 DR. BUTT: All right. Thank you.

3 DR. SHEPLEY: I'm happy with the arrangements.

4 MR. WHITNEY: Dr. Shepley, I first want to  
5 state, leading up to my question, as a personal reaction that I  
6 have been personally impressed with the amount of medical aid  
7 that the profession does give. I think the general public,  
8 like myself, doesn't realize the extent of it. I think the  
9 medical profession has done an excellent job under the Welfare  
10 Acts, there are seven of them listed on the back of the Bill,  
11 to extend this medical aid, and there has been some talk, as  
12 you have mentioned, about whether this should stay under the  
13 Medical Welfare Plan.

14 Putting the question, I think it's pretty much  
15 Dr. Butt's question placed another way, there will be more  
16 indigents likely, not created, but found to be included in  
17 this plan as it becomes better known, and so on. The accoun-  
18 tants have given us some figures that indicate that there will  
19 be an increase in the welfare patient.

20 Are you suggesting that the continued subsidiza-  
21 tion of this ever-growing group by the medical profession  
22 should be continued, or should the premium, however it is  
23 collected, whether it is paid out of tax money, or wherever  
24 it comes from, should now be raised to the level where subsi-  
25 dization of what the medical profession is doing will be

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1 lessened, and these welfare patients' services should be pretty  
2 much brought up to the O.M.A. Schedule?

3 Has this entered your thinking? I just want an  
4 expression of your feeling.

5 DR. SHEPLEY: It has been our feeling that over  
6 the years the provision of in-hospital care without charge to  
7 the indigent group has not been too great a burden, but we have  
8 been concerned about the extension into more and more aspects  
9 of our social welfare, and we believe that it should be  
10 expected that in the development of the present legislation  
11 and its basic principles the coverage for medical compensation  
12 should extend in some way.

13 We haven't been too concerned about the degree.  
14 It should extend in some way to take care of medical services  
15 in hospital to the totally subsidized group.

16 MR. WHITNEY: My second question is this: when  
17 you suggest the deletion of Schedule B, are you really sugges-  
18 ting we don't need it, and should cover it all under Schedule  
19 A?

20 DR. SHEPLEY: Yes.

21 MR. WHITNEY: I see. So that whether the  
22 services are performed in hospital or out of hospital it  
23 would be the same thing?

24 DR. SHEPLEY: That's right.

25 MR. MULROONEY: I understand, Doctor, that the



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much brought up to the O.M.A. Schedule?



1 Kent County Medical Society is a component of the Ontario  
2 Medical Association; is this correct?

3 DR. SHEPLEY: Yes.

4 MR. MULROONEY: Can you tell me whether the  
5 recommendations, and specifically, the recommendation with  
6 regard to the subsidized people, is the policy -- are you  
7 expressing, if you like to put it another way, the opinion of  
8 the Ontario Medical Association, or are you speaking only for  
9 your own Society?

10 DR. SHEPLEY: Mr. Chairman, can I ask Dr. Pack-  
11 ham to reply to that?

12 THE CHAIRMAN: Certainly.

13 DR. PACKHAM: You are speaking of Item 5 of the  
14 recommendations

15 MR. MULROONEY: Specifically, yes.

16 DR. PACKHAM: Well, this is the opinion of the  
17 Ontario Medical Association also.

18 MR. MULROONEY: One further question, Mr. Chair-  
19 man. I wonder whether the recommendation is based on the idea  
20 that medical doctors should be compelled to continue to provide  
21 some measure of their services gratis? That is, to accept some-  
22 thing less than the present schedule of fees for the care of  
23 the indigents.

24 This is an act of charity. This seems to be  
25 implicit in the suggestions so far.

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4 1 DR. SHEPLEY: I think, Mr. Chairman, that our  
2 reaction to that would be that our first recommendation is the  
3 one that we really feel underlines our whole philosophy, that  
4 legislation should avoid interference with doctor-patient  
5 relationship, and in that relationship there is no compulsion.

6 MR. MULROONEY: Thank you.

7 MR. SIMON: Doctor, you speak, in your brief,  
8 about comprehensive and extended care. Can you give us a  
9 definition of what you mean by comprehensive care? Would  
10 that include nursing care, medicine and rehabilitation services,  
11 and things of that kind, or is it narrowed to something else?

12 DR. SHEPLEY: Essentially Schedule A.

13 MR. SIMON: You're referring to Schedule A of  
14 the Bill?

15 DR. SHEPLEY: Yes.

16 MR. SIMON: Talking about community pooling,  
17 can you visualize the situation where in some centres in  
18 Ontario there are a lot of retired people, older people, and  
19 if you pool them only on a community basis, you would have a  
20 higher cost for their medical care in certain communities, as  
21 compared to others where there is an average age group?

22 DR. SHEPLEY: Just to avoid that problem, we  
23 really mean by community rate, community rate is provincial,  
24 province-wide.

25 MR. SIMON: You weren't too clear in the

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relationship, and in that relationship there is no compensation legislation should avoid interference with doctor-patient one that we really feel underlines our whole philosophy, that



1 language.

2 MISS CARPENTER: Under the Medical Welfare Plan  
3 as it is currently operated, does the physician know when he  
4 is treating a patient that the patient is medically indigent?

5 DR. SHEPLEY: Mr. Chairman, yes, we do.  
6 Patients come to us and present a medical identification card,  
7 or a voucher.

8 Now, there are many instances when the relief  
9 recipient in the local municipality may appear, and not present  
10 a medical identification voucher, and we may not know for  
11 several weeks, or months, that they have been receiving municipi-  
12 pal relief, and that they are entitled to their medical care  
13 through the Medical Welfare Plan.

14 But, by and large, the greatmajority of these  
15 identify themselves with the physician by presenting a medical  
16 identification voucher, or card, which we, as participating  
17 physicians in the Plan, will sign, and send into the Medical  
18 Welfare Plan.

19 MISS CARPENTER: I was wondering -- a second  
20 question -- is it in the best interests of the patient that he  
21 is identified as an indigent individual?

22 DR. SHEPLEY: I think it is.

23 MISS CARPENTER: Why?

24 DR. SHEPLEY: There are two reasons. I think  
25 that in all of us there is inborn a sense of human charity;



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1 and the other is that from a practical point of view you just  
2 don't send him a bill.

3 THE CHAIRMAN: I'm sorry. I didn't hear that.  
4 From the practical point of view you what?

5 DR. SHEPLEY: You just don't send him a bill.

6 MR. CASWELL: Doctor, it has been brought out  
7 here that over the years the medical profession have subsi-  
8 dized the welfare cases, and this we know is true, and it's  
9 also been brought out that under Bill 163 it's very likely  
10 that indigent, or welfare, cases will substantially increase,  
11 and if such were the case, and the medical profession were paid  
12 100%, they were not called upon to subsidize, there would be  
13 a lot more cases, and they would get 100% fee.

14 Would this, then, result, do you think, in a  
15 lowering of the schedule of fees of the Ontario Medical Asso-  
16 ciation, because of the larger volume paying 100% of the cost?

17 DR. SHEPLEY: Mr. Chairman, I think we, as a  
18 Branch Society, discussed the aspects of this, and I feel it  
19 would be a matter which would more appropriately be directed  
20 to the Ontario Medical Association when they present their  
21 brief.

22 MR. CASWELL: Thank you.

23 DR. GALLOWAY: I wanted to make sure that all  
24 these recommendations aren't being referred to as those of the  
25 Ontario Medical Association, but just No. 5. They aren't



THE CHAIRMAN: I'm sorry. I didn't hear that.

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1 necessarily the recommendations of the Ontario Medical Associa-  
2 tion.

3 DR. SHEPLEY: No, none of them are necessarily  
4 the recommendations of the Ontario Medical Association, but I  
5 think we said in the opening remarks that where they are  
6 recommended by other organizations we present them for consi-  
7 deration on their own merit, or to emphasize those presented  
8 by any others.

9 DR. GALLOWAY: Somebody asked the question  
10 whether No. 5 was the opinion of the Ontario Medical Associa-  
11 tion, and I suspect it likely is. I suspect that many of the  
12 others aren't.

13 For example, you've had a very unusual  
14 experience, you said, with the service-type plan, and for this  
15 reason you've recommended the removal of the Schedule B cases,  
16 and in support of this you have made several comments regarding  
17 hospitals and admissions in No. 9. In other areas of the  
18 province I'm sure there has been a satisfactory arrangement  
19 between physicians, patients and insurance carriers who use  
20 the indemnity type, and others are only catastrophic coverage,  
21 such as Schedule B offers for them, only because they want  
22 that particular type, and we don't know, and I'm sure you can't  
23 tell us, what that percentage of people is.

24 Do you think it would be wise to limit the rest  
25 of the province in view of your experience here?



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Do you think it would be wise to limit the number of the province in view of your experience here?



1 DR. SHEPLEY: Mr. Chairman, in answer to that  
2 we felt that we should present this as our opinion following  
3 our experience, recognizing that it would be stacked against  
4 the opinions expressed by other areas, and that the Enquiry  
5 in its good judgment, would then assess all of these attitudes  
6 and ideas, and by so doing come up with what we would, I'm  
7 quite sure, feel would be the best after assessing all of  
8 these.

9 We don't believe that ours is the only one.  
10 We believe that it should be considered side by side with  
11 other briefs, other ideas, other presentations, and from our  
12 experience this has been our feeling.

13 Following assessment of the broad areas of the  
14 province, it may very well be that our experience here is not  
15 applicable elsewhere, but nevertheless we feel that what has  
16 happened should have a bearing on the opinion of the Enquiry  
17 in assessing the overall situation.

18 DR. GALLOWAY: That was very well answered, Dr.  
19 Shepley.

20 The only other point I would like to argue  
21 about, again, is this paragraph No. 9, in which you have indi-  
22 cated that pressure would be placed on the doctors, and in (c)  
23 the same sort of pressure, I imagine, for out-patient diagnostic  
24 services.

25 If some plan, or arrangement, for increased



DR. SHEPLEY: Mr. Chairman, in answer to that

we felt that we should present this as our opinion following our experience, recognizing that it would be attacked against the opinions expressed by other areas, and that the Faculty in its good judgment, would then assess all of these attitudes and ideas, and by so doing come up with what we would, I'm quite sure, feel would be the best after assessing all of these.

We don't believe that ours is the only one.

We believe that it should be considered side by side with other briefs, other ideas, other presentations, and from our

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DR. GALLIOWAY: That was very well answered, Dr.

Shepley.

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In some plan, or arrangement, for increased



1 payment for out-patient diagnostic services were developed,  
2 would these opinions still hold?

3 DR. SHEPLEY: I think, Mr. Chairman, the answer  
4 to that would depend on -- do you mean increased payment to  
5 the physician in attendance, not payment to the hospital?

6 DR. GALLOWAY: Payment for the services, what-  
7 ever type they are.

8 DR. SHEPLEY: To the physician attending the  
9 patient?

10 DR. GALLOWAY: I think one of the reasons, for  
11 example, I'm sure you have put this in, is that pressure would  
12 be put on you if you had a patient who needed x-rays of the  
13 stomach, and those who carry Schedule B would require to go  
14 into hospital to have this done.

15 If, however, a plan were developed in which  
16 there were benefits in the plan so that x-rays could be paid  
17 for on an out-patient basis, would this not reverse the situa-  
18 tion? Would the pressure not be off the doctor to admit the  
19 patient into hospital, and would you still consider these argu-  
20 ments valid?

5 21 DR. SHEPLEY: By the application of Schedule A  
22 it's our understanding that x-rays will be part of the benefits,  
23 wherever they were taken, in or out of hospital.  
24 I'm sorry, I just don't follow your question, Dr.  
25 Galloway.

would these opinions still hold?

DR. SHEPHERD: I think, Mr. Chairman, the answer

to that would depend on -- do you mean increased payment to

the physician in attendance, not payment to the hospital?

DR. GALLOWAY: Payment for the services, what-

ever type they are.

DR. SHEPHERD: To the physician attending the

patient?

DR. GALLOWAY: I think one of the reasons, for

example, I'm sure you have put this in, is that pressure would

be put on you if you had a patient who needed x-rays of the

stomach, and those who carry Schedule B would require to go

into hospital to have this done.

If, however, a plan were developed in which

there were benefits in the plan so that x-rays could be paid

for on an out-patient basis, would this not reverse the situa-

tion? Would the pressure not be off the doctor to admit the

patient into hospital, and would you still consider these argu-

ments valid?

DR. SHEPHERD: By the application of Schedule A

it's our understanding that x-rays will be part of the benefits

wherever they were taken, in or out of hospital.

I'm sorry, I just don't follow your question, Dr.





1 DR. GALLOWAY: Well, maybe I'm wording it  
2 incorrectly, but I'll try again.

3 At the present moment you have used as an  
4 argument for getting rid of Schedule B these pressures that  
5 are placed on doctors by patients to admit them to hospital,  
6 therefore increasing the demand for beds.

7 On the other hand, if an insurance plan is  
8 developed which allows greater benefits, so that the patients  
9 may have out-patient diagnostic services paid for, and still  
10 be under Schedule B in the type of insurance that they get,  
11 there would be no demand to enter hospital, and they could be  
12 done as out-patients.

13 THE CHAIRMAN: Are we going over things here  
14 that will be repeated again in the Ontario Medical Association's  
15 brief?

16 DR. GALLOWAY: I have not seen the Ontario  
17 Medical Association brief, sir, and I'm quite willing to drop  
18 this point.

19 THE CHAIRMAN: I don't want to cut off discus-  
20 sion.

21 MR. WHITNEY: What would you think, just briefly,  
22 Doctor, with Schedule B left in, and this is just a shot out  
23 of the dark, with Schedule B left in with the patient paying  
24 the first week or two?

25 This is purely a personal question I'm asking

DR. GALLOWAY: Well, maybe I'm wording it

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1 you.

2 DR. SHEPLEY: May I answer it personally, then?

3 I would feel that it wouldn't be in keeping with the philosophy  
4 of the Bill. I think the Bill's philosophy basically is to  
5 try to provide services and payment under the insurance prin-  
6 ciple, and to have something acting against that would be  
7 basically just not in keeping with the aspirations that I  
8 believe are included in this Bill.

9 MR. WHITNEY: It might discourage the over-  
10 utilization of the hospital but, as you say, it would be  
11 against the philosophy?

12 DR. SHEPLEY: That's right.

13 THE CHAIRMAN: Are there any further questions?  
14 Thank you very much, Doctor.

15 We will reconvene at 2 o'clock. We might try  
16 to be here about five minutes beforehand, so that we can get  
17 started sharply at two.

18

19 --- Luncheon adjournment.

20

21

22

23

24

25





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1 ---On commencing at 2:00 p.m.

2 THE CHAIRMAN: I think we will start at this  
3 time and take it for granted that the other members of the  
4 Enquiry will arrive previous to our getting into the substance  
5 of that which is to be discussed.

6 The delegation from the Windsor Medical Services  
7 Incorporated is here, I presume. I will read the instructions  
8 that have been read to all delegations.

9 "Members of the Enquiry have received and  
10 studied the brief you submitted. In accordance with the guide  
11 for participation in hearings that was mailed to you, it will  
12 not be necessary for you to read your brief, but you do have an  
13 opportunity to emphasize or enlarge upon its conclusions or  
14 recommendations.

15 Members of the Enquiry may ask you questions on  
16 the statements or recommendations submitted in your brief, but  
17 you are not to be subjected to examination or cross-examination  
18 by other persons.

19 It is not our intention to debate your sugges-  
20 tions or recommendations, nor to state the views of this  
21 Enquiry on them. Consequently, any opinions expressed in  
22 questions asked or statements made by members of the Enquiry  
23 are intended for clarification only.

24 As stated in the instructions, one person is to  
25 act as your spokesman. However, if the spokesman feels that



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1 another member is better qualified to answer a specific  
2 question from a member of the Enquiry, the spokesman may receive  
3 the Chair's permission to request the other member to answer.

4 Will you please identify your spokesman, and then  
5 proceed.

6 The members of the press have requested a copy  
7 of your brief, and if you have copies with you, perhaps you  
8 will hand them to the members of the press at the conclusion  
9 of your submission.

10  
11 SUBMISSION OF  
12 WINDSOR MEDICAL SERVICES INCORPORATED

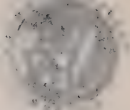
13 Appearances: Dr. E. Durocher  
14 Dr. E. A. Roemmele  
15 Dr. J. R. Barber  
16 Mr. W. V. Walpole

17 THE CHAIRMAN: Will you please identify now  
18 who is to be your spokesman?

19 MR. WALPOLE: Mr. Chairman, my name is Vern  
20 Walpole, Windsor Medical Services. I will act as spokesman  
21 for the group here. I would like to introduce at this time  
22 on my left our president, Dr. Durocher, on my right, Dr.  
23 Roemmele, vice-president, and Dr. J. R. Barber, on my extreme  
24 right, also a member of our Board.

25 THE CHAIRMAN: Will you proceed then, please.

MR. WALPOLE: I would like to say, Mr. Chairman,  
that we are happy to have this opportunity to present our brief



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that we are happy to have this opportunity to present our brief



1 to the Committee of Enquiry re Bill 163.

2 Windsor Medical Services is a pre-paid doctor-  
3 sponsored medical service plan, operating in the Counties of  
4 Essex and Kent in the Province of Ontario. We have been in  
5 operation for a goodly number of years, having received our  
6 charter in 1937, and in a relatively confined area in these  
7 two counties which, in the 1961 census, represented some  
8 347,645 persons of which our enrolment today embraces some  
9 236,000 persons, or roughly 68-70% of the total population of  
10 those two counties.

11 We are here to co-operate with the Committee.  
12 We do not profess to have all the answers. However, we are  
13 here to do our best to clarify anything, any statement that we  
14 have made in our brief and the recommendations contained therein.  
15 We would be quite happy to receive the questions of the members  
16 of the Committee.

17 THE CHAIRMAN: Thank you. Dr. Butt?

18 DR. BUTT: I might say at the outset that I know  
19 a few of the gentlemen on the delegation and have had an  
20 opportunity of talking with them before, so I can't feel that  
21 I can say any question is personal, but they are not to be  
22 taken in that light. I will just ask a few questions. The  
23 first one I had, and I think it was asked this morning, was your  
24 opinion on Schedule C, coverage outlined in Schedule C be  
25 provided through the Medical Welfare Plan. That is in your





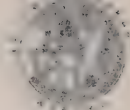


1 recommendation number seven, and I believe you probably heard  
2 the questions this morning. Would you have anything further  
3 to say about this?

4 MR. WALPOLE: Our recommendation number seven  
5 reads:

6 "That coverage for those persons outlined in  
7 Schedule C be provided through the Medical  
8 Welfare Plan."

9 I think perhaps that might be taken in two stages. First of  
10 all, just to glance over those seven acts, I believe, outlined  
11 in Schedule C, you will note that we are dealing with a  
12 particular segment of our population which, in my opinion, is  
13 rather unique in this respect that there is a goodly measure  
14 of disability embodied in the very nature of these Acts: The  
15 Blind Persons' Act, the Disabled Persons Act, the Old Age  
16 Assistance Act, the Old Age Security Act, the Rehabilitation  
17 Services Act and purely from that consideration only, I would  
18 like to first put forward the thought that the seventh  
19 recommendation that one carrier only provide coverage for this  
20 segment of our population; then coming down to the fact that  
21 we have recommended that the Medical Welfare Plan remain intact,  
22 I think it is important to recognize the fact that over the  
23 years there have been fairly firm lines of communication  
24 established between the Medical Welfare Department of the  
25 Province of Ontario and the Medical Welfare Plan operated by the



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to say about this?

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1 Ontario Medical Association.

2 Then we have the changing complexity in this  
3 particular group of individuals because today they may be  
4 eligible for coverage under some of these Acts and tomorrow  
5 they are not. So it is in a state of flux. Therefore, to put  
6 this out into a multiple-carrier area or to a carrier who is  
7 not fully conversant with the ramifications of what goes on  
8 in this particular group, such as the administration of the  
9 Medical Welfare Plan, it would seem to me to be breaking new  
10 ground. And that leads me into the other thought, that in  
11 breaking new ground here we would have the people who have been  
12 covered for home and office care only. They have received all  
13 the medical care; they have not been denied that. I am talking  
14 only of the economics of it at the moment. I mentioned earlier  
15 that inherent in this thing, there is a certain amount of dis-  
16 ability. So here again we are breaking new ground and, in  
17 doing so, I feel that there may be some necessity for an under-  
18 writing type of contract, such as was discussed here yesterday  
19 in one of the other briefs, and if there is going to be an  
20 underwriting type of contract, I would say then it would be  
21 much better for the medical profession to have that under their  
22 control.

23 DR. BUTT: Thank you. I wondered, in recommenda-  
24 tion number eleven, can you amplify it slightly? In other  
25 words, I am not quite sure I understand what you mean that only

Then we have the changing complexity in this particular group of individuals because today they may be eligible for coverage under some of these Acts and tomorrow they are not. So it is in a state of flux. Therefore, to put this out into a multiple-carrier area or to a carrier who is not fully conversant with the ramifications of what goes on in this particular group, such as the administration of the Medical Welfare Plan, it would seem to me to be breaking new ground. And that leads me into the other thought, that in breaking new ground here we would have the people who have been covered for home and office care only. They have received all the medical care; they have not been denied that. I am talking only of the economics of it at the moment. I mentioned earlier that inherent in this thing, there is a certain amount of disability. So here again we are breaking new ground and, in doing so, I feel that there may be some necessity for an underwriting type of contract, such as was discussed in the preceding in one of the other bullet, and if there is going to be underwriting type of contract, I would say then it would be much better for the medical profession to have their underwriting words, I am not quite sure I understand what you mean that only

DR. HUNT: Thank you. I would like to see some



1 those persons or "from those persons only who are without  
2 coverage at the initial enrollment period or any subsequent  
3 open enrollement period."

4 MR. WALPOLE: Bill 163, at the moment, makes no  
5 provision for a carrier to decline an application. This, in  
6 a sense, takes some of that away; however, it does not eliminate  
7 or preclude a person having a choice of carriers. I think it  
8 can be safely said that any carrier who has seen fit to carry  
9 a person in a group for a period of time must bear some moral  
10 responsibility for the continuation of the coverage of that  
11 particular individual; that that being the case, then he should  
12 bear the responsibility of providing coverage for the person  
13 when he terminates his group coverage and he may apply to the  
14 incumbent carrier for continuation of a standard medical  
15 service contract. However, he may also apply to any other ---  
16 Pardon me. May I back up just a moment. It must be mandatory  
17 on that incumbent carrier to accept his application. However,  
18 he can then go out on the open market and seek any other  
19 carrier, but there would be no compulsion on the part of a  
20 given carrier to accept that application.

21 DR. BUTT: To clarify it, you mean he would have  
22 double coverage?

23 MR. WALPOLE: It could be possible that he  
24 would -- could have double coverage until he had fulfilled his  
25 late enrolment waiting period and then he could drop one or the





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5 provision for a carrier to decline an application. This, in  
6 a sense, takes some of that away; however, it does not eliminate  
7 or preclude a person having a choice of carriers. I think it  
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16 carrier. May I back up just a moment. It must be necessary  
17 on that incumbent carrier to accept his application. However,  
18 he can then go out on the open market and  
19 carrier, but there would be no competition on the part  
20 given carrier to accept that application.  
21 MR. BROWN: It clearly is, you mean he would have  
22 double coverage?  
23 MR. WALFORD: It would be possible that he  
24 would -- could have double coverage until he had fulfilled his  
25 late enrollment waiting period and then he could drop one or the



1 other.

2 DR. BUTT: Going on to page 2, Schedule B, I  
3 think this was discussed to some extent this morning. As an  
4 alternative, I think you said Schedule B is a catastrophic type  
5 of insurance, and I think one objection to it is, I believe,  
6 that it produces a greater push on the beds and the utiliza-  
7 tion of beds as opposed to the schedule, which does not?

8 MR. WALPOLE: That is true.

9 DR. BUTT: Suppose you had a really catastrophic  
10 situation in which your first two weeks in hospital did not  
11 count -- in other words, only the patient who is going to be  
12 in hospital for two or three weeks or more; would this be a  
13 relatively low premium to perhaps look after just the catas-  
14 trophic situation? Have you any comments on that type of  
15 thinking?

16 MR. WALPOLE: I would say that that would have  
17 somewhat of an effect on the demand by the patient of his  
18 physician.

19 DR. BUTT: The point is that the first two weeks  
20 would be of no use to him; he has got to be in there longer  
21 than that?

22 MR. WALPOLE: I am sorry. I have one point of  
23 clarification. Are you talking of hospitalization or are you  
24 talking of the medical aspect?

25 DR. BUTT: I am talking of the medical aspect



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1 pure and simple. This is what the Bill is dealing with. It  
2 is going to be the true catastrophic situation that you are  
3 talking about.

4 MR. WALPOLE: Then if I interpret your question,  
5 Dr. Butt, this individual having no medical coverage during  
6 that period, ten days or two weeks -- no medical coverage  
7 during that period of time ...

8 DR. BUTT: Well, this is not quite right. I  
9 guess we will have to get down to an example. I am thinking  
10 of the patient that is going to have a long-term illness.  
11 Where are you going to define it? In other words, they are  
12 going to have to be in hospital for a long time -- and nothing  
13 else?

14 MR. WALPOLE: I think before I could answer  
15 your question ...

16 DR. BUTT: I know. You would have to know  
17 exactly what I had in mind?

18 MR. WALPOLE: That is right.

19 DR. BUTT: This primarily was the patient who  
20 would be in hospital for a long time and unless it was of that  
21 type or nature that would require this patient to be in  
22 hospital for a long time, there would be no medical coverage?

23 MR. WALPOLE: I would make only one comment:  
24 That is the fellow who is there the eleventh day, he should  
25 have been discharged on the tenth day, he would still put

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1 pressure on to be there for the eleventh day in order to get  
2 the whole thing paid.

3 DR. BUTT: Thank you. You answered it very  
4 well.

5 MR. NAYLOR: Mr. Walpole, on page 8 of your  
6 brief you suggest, at the bottom, a revision of Section 5 of  
7 Bill 163. And I think in answer to one of Dr. Butt's questions  
8 you explained the reasons for the second part of it, and I  
9 can quite appreciate them. That is where you have a person  
10 leaving a group, it seems quite reasonable that it should be  
11 the responsibility of the carrier that he has been with in the  
12 group to give him a continuation of coverage. However, I am  
13 not quite sure that I understand the implications of the  
14 implications of the first section or the reasons for it. It  
15 seems to me that the effect of it is that during the initial  
16 enrolment period, carriers will be required to offer the  
17 standard plan only to those who have no coverage at all. If  
18 that is the intention, I just wonder why you think they should  
19 not be required to offer the standard plan to those who might  
20 have a limited form of coverage -- something less than the  
21 standard plan?

22 MR. WALPOLE: I think this could lead to a degree  
23 of anti-selection. The person who has been covered by a limited  
24 type of program and perhaps he is in that unfortunate position  
25 of having to require a great deal of medical care, for which he



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1 was not covered under the limited type of program, then as soon  
2 as you open that up, all these people are naturally going to  
3 gravitate into the other areas, which causes a certain degree  
4 of anti-selection.

5 MR. NAYLOR: Well that is a possibility;  
6 although I suppose it is not any more likely to happen there  
7 than in the case of a person who has no coverage at all.  
8 Furthermore, as you probably know, one of the basic ideas of  
9 this whole plan is that coverage is to be universally available  
10 and I just wondered if the government would feel that it was  
11 doing what is intended if the persons who have some kind of  
12 coverage, and that may be substantially less than the standard  
13 plan, would not be given the right to get a standard plan?

14 MR. WALPOLE: I would have to agree that there  
15 is some element of freedom here.

16 MR. NAYLOR: Would you have any great strong  
17 objection, or do you see any strong objection to leaving  
18 Section 5 as it was, insofar as the initial enrolment period  
19 is? In other words, that any carrier that is operating in the  
20 field will have to offer the standard plan to anyone in less  
21 than the enrolment period, whether they have coverage or not?

22 MR. WALPOLE: I still wonder if this would not  
23 eventually right itself and I think we have to clarify two  
24 things here. One is that there are two types of coverage  
25 available to citizens of the Province of Ontario on a routine



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objection, or do you see any strong objection to leaving Section 5 as it was, insofar as the initial enrolment period is? In other words, that any carrier that is operating in the field will have to offer the standard plan to anyone in less than the enrolment period, whether they have coverage or not?

MR. WALPOLE: I still wonder if this would not eventually right itself and I think we have to clarify two things here. One is that there are two types of coverage available to citizens of the Province of Ontario on a routine





1 basis; one being on a group basis, the other being on an  
2 individual basis. And I think if this is the particular type  
3 of program which I am talking about here, first of all, as I  
4 understand Bill 163, it is primarily geared to the individual,  
5 rather than to a group. It seems to me that the fellow who is  
6 going to be upgraded will be more likely to be these in a  
7 group than perhaps in the individual categories and this might  
8 have the effect of upgrading coverage in groups, if what we  
9 have proposed here were to remain intact.

10 MR. NAYLOR: I do not believe I understand your  
11 point. You say this might have the effect of upgrading the  
12 coverage in a group?

13 MR. WALPOLE: Yes. Generally, the urging comes  
14 from the people who are covered under the group. Not too often  
15 the group itself desires this; it is the urging of the partici-  
16 pants in that group and if enough people in that group urge  
17 upon his or her employer to upgrade their coverage, simply to  
18 take advantage of what we are talking about here, then I think  
19 this will bring us into that area.

20 MR. WHITNEY: Is there anything wrong with that?

21 MR. WALPOLE: No. I agree entirely.

22 MR. NAYLOR: I think that is enough on that  
23 particular point. I have one or two other questions. On page  
24 13, as I understand your Section 41, you suggested the makeup  
25 of the Board of Directors of Medical Carriers Incorporated as



individual basis. And I think if this is the particular type of program which I am talking about here, first of all, as I understand Bill 163, it is primarily geared to the individual, rather than to a group. It seems to me that the fellow who is going to be upgraded will be more likely to be those in a group than perhaps in the individual categories and this might have the effect of upgrading coverage in groups, if what we have proposed here were to remain intact.

MR. NAYLOR: I do not believe I understand your point. You say this might have the effect of upgrading the coverage in a group?

from the people who are covered under the group. Not too often the group itself desires this; it is the urging of the particular people in that group and if enough people in that group urge upon his or her employer to upgrade their coverage, simply to take advantage of what we are talking about here, then I think this will bring us into that area.

MR. WHITNEY: Is there anything wrong with that?

MR. NAYLOR: I think that is enough on that particular point. I have one or two other questions. On page 13, as I understand your Section 41, you suggested the members of the Board of Directors of Medical Carriers Incorporated as

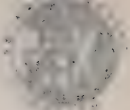


1 two members from the licensed insurance companies and five  
2 other members: One from the Co-Operatives, one from Cumba  
3 and one from each of the three doctor-sponsored plans; do you  
4 think that is a very fair representation?

5 MR. WALPOLE: I would have to answer, Mr.  
6 Chairman, Mr. Naylor's question in this fashion: I think  
7 considering the contracts in force, bodies covered, that this  
8 would be a fair representation. I do not agree that -- for  
9 the lack of a better word, let us call it thin coverage --  
10 should carry the same weight as comprehensive coverage which  
11 provides for home and office care, for hospital care, for  
12 surgery, for maternity, and so on. And to come back to what  
13 I meant by thin coverage, a good example of that would be we  
14 had a number of years ago polio coverage and I do not think  
15 that we can mix these two together and call them either apples  
16 or oranges. They are two different breeds. So I think the  
17 coverage represented by these people, as we have set them forth  
18 here, fairly represents comparable coverage today.

19 MR. NAYLOR: One other question. On page 18,  
20 you suggest that it is unethical to collect premiums for the  
21 waiting period of three months, which would be applicable to  
22 persons applying after the initial enrolment period. I am not  
23 sure I understand your thinking there. It is true that while  
24 they have paid premiums for that period they couldn't collect  
25 any benefits; but, nevertheless, they are receiving a very





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should carry the same weight as comprehensive coverage which  
provides for home and office care, for hospital care, for  
surgery, for maternity, and so on. And to come back to what  
I meant by thin coverage, a good example of that would be we  
had a number of years ago police coverage and I do not think  
that we can mix these two together and call them either police  
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coverage represented by these people, as we have set them forth  
here, fairly represents comparable coverage today.

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any benefits; but, nevertheless, they are receiving a very



1 valuable concession in being permitted to take out a policy,  
2 to defer taking out a policy until they think they are going  
3 to need it. That is a real valuable privilege that we are  
4 giving. In fact, there may be some question as to whether we  
5 are charging them enough by simply charging them three months'  
6 premiums to offset the anti-selection. I was interested in  
7 knowing what your experience is. I gather, from some figures  
8 in the brief, that you do have your non-group policy that an  
9 individual can buy and that you have a fair number of persons  
10 covered under that. You have had it for a few years. I would  
11 be interested in knowing what you do to offset the anti-  
12 selection? Do you have a waiting period? Do you charge  
13 premiums only from the end of the waiting period? And what  
14 has your experience been in these individual risks, as compared  
15 to the group enrolment?

16 MR. WALPOLE: I will try to take that as much  
17 in the order as you have given it as possible. First of all,  
18 there is just one point in respect of the ethical part of  
19 this. There are only two things that we can purchase in this  
20 life. Those two things are goods and services. Let us take  
21 goods, for the moment. Suppose the housewife wishes a new  
22 washing machine and she goes down to the dealer and he says:  
23 "Yes, Mrs. X., this machine is \$144.00. First of all, though,  
24 before you get the machine you pay me three payments. Then we  
25 deliver the machine and you start paying 12 payments of \$12.00



1 valuable consideration in being permitted to take out a policy  
2 to defer taking out a policy until they think they are going  
3 to need it. That is a real valuable privilege that we are  
4 giving. In fact, there may be some question as to whether we  
5 are charging them enough by simply charging them three months'  
6 premiums to offset the anti-reflection. I was interested in  
7 knowing what your experience is. I gather, from some figures  
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15 to the group enrollment?  
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17 in the order as you have given it as possible. First of all,  
18 there is just one point in respect of the ethical part of  
19 this. There are only two things that we can purchase in this  
20 life. Those two things are goods and services. Let us take  
21 goods, for the moment. Suppose the housewife wishes a new  
22 washing machine and she goes down to the dealer and he says  
23 "Yes, Mrs. X., this machine is \$127.00. First of all, though  
24 before you get the machine you pay me three payments. Then  
25 deliver the machine and you start paying 12 payments of \$12.00





1 a month, plus interest." I think we would take a very dim view  
2 of this. This is the basis on which we are making the state-  
3 ment that it is unethical to collect something for which we are  
4 not delivering either goods or services.

5 Now, our method of handling our non-group. We  
6 accept applications from the man on the street, without any  
7 restriction as to age or state of health, and this follows this  
8 schedule: A subscriber, a man or a woman, applies to us during  
9 the month of January -- any time during the month of January --  
10 and he pays to us an enrolment fee of \$2.00, plus the appro-  
11 priate premium for one month, or two months or whatever he might  
12 desire to pay, and his coverage then becomes effective on the  
13 first day of May. If he pays one month's premium, that  
14 premium applies to the month of May.

15 MR. NAYLOR: Is that a five months' waiting  
16 period?

17 MR. WALPOLE: No. It is three clear calendar  
18 months. It can be stretched to almost four. If he applied on  
19 the 2nd of January, it is almost four.

20 Your other question was as to our experience.  
21 Our experience has been that this is a costly group. But this  
22 does not shake us too much when we have analyzed this particular  
23 enrolment. In this enrolment, we have a very high degree of  
24 the upper-age group, over age 65. It is about 25 or 26% of  
25 our total enrolment in that particular field and this is

a moment, plus interest." I think we would take a very dim view of this. This is the basis on which we are making the statement that it is unethical to collect something for which we are not delivering either goods or services.

Now, our method of handling our non-group. We accept applications from the man on the street, without any restriction as to age or state of health, and this follows this schedule: A subscriber, a man or a woman, applies to us during the month of January -- any time during the month of January -- and he pays to us an enrollment fee of \$2.00, plus the appropriate premium for one month, or two months or whatever he might desire to pay, and his coverage then becomes effective on the first day of May. If he pays one month premium applies to the month of May.

MR. WATSON: Is that a five month waiting period?

MR. WATSON: No. It is three after enrollment months. It can be stretched to almost four. If he applied on the 2nd of January, it is almost four.

Your other question was as to our experience. Our experience has been that there is a steady group. This does not shake us too much when we have analyzed this particular enrollment. In this enrollment, we have a very high degree of



1 understandable when you look back over the years and find that  
2 carriers were reluctant to continue the coverage of those  
3 persons beyond age 65. In many instances, they were dropped  
4 like hot potatoes and we now have these persons coming into  
5 our enrolment in the high cost area and, naturally, this gives  
6 us a sharp incline in the curve in the cost picture.

7 MR. NAYLOR: Is it true that your premiums are  
8 not covering claims for that particular group, or do you wish  
9 to say?

10 MR. WALPOLE: I would rather reserve that.

11 MR. NAYLOR: Yes, fine.

12 THE CHAIRMAN: Mrs. Aylen?

13 MRS. AYLEN: Mr. Chairman, I would like to ask  
14 Mr. Walpole this. On page 22, recommendations, number 65,  
15 you recommend, I believe, that the annual or periodic health  
16 examinations should be a benefit. Do you have such a benefit  
17 in your plan?

18 MR. WALPOLE: Yes, we do.

19 MRS. AYLEN: Is it one or two times a year?

20 MR. WALPOLE: One in a twelve month period.  
21 Twelve months must elapse between examinations.

22 MRS. AYLEN: If a plan did not include that,  
23 do you think that it could be, the privilege could be sought  
24 under other means? Do you think that people could have those  
25 examinations under some other guise?



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us a sharp incline in the curve in the cost picture.

MR. MAYOR: Is it true that your program was  
not covering claims for that particular group, or do you wish  
to say?

MR. WALPOLE: I would rather reserve that.  
MR. MAYOR: Yes, sir.

THE CHAIRMAN: Mr. Allen?  
MRS. ALLEN: Mr. Chairman, I would like to ask

Mr. Walpole this. On page 12, recommendations, number 6  
you recommend, I believe, that the annual  
examinations should be a benefit. Do you have any specific  
in your plan?

MR. WALPOLE: Yes, we do.  
MRS. ALLEN: Is it one or two times a year?

MR. WALPOLE: One in a twelve month period.  
Twelve months must elapse between examinations.  
MRS. ALLEN: Is a plan that not include that?

do you think that it could be, the privilege could be granted  
under other means? Do you think that people would have those  
examinations under some other plan?



1 MR. WALPOLE: Yes.

2 MRS. AYLEN: So you think it might be just as  
3 well to include them?

4 MR. WALPOLE: Yes, this is true.

5 MRS. AYLEN: On page 21, I was extremely  
6 interested in your formula there and, not being too familiar  
7 with insurance plans, can you tell me, as a layman, how you  
8 worked out that formula? I mean, is it in use at all?

9 MR. WALPOLE: Yes. The three rate structure is  
10 not an unusual rate structure. I do not know whether this  
11 answers your question or not, or are you referring to the exact  
12 formula that we have here in front of us?

13 MRS. AYLEN: Yes.

14 MR. WALPOLE: The "x", "2x" and " $2\frac{1}{2}x$ ". Is that  
15 correct?

16 THE CHAIRMAN: That is the one on page 21.

17 MRS. AYLEN: Yes.

18 MR. WALPOLE: I can go into that a little  
19 further. Let us use round figures here. Let us use  
20 four dollars for a single premium. We double that premium for  
21 a 2-person contract, which would be eight dollars and then we  
22 say two and a half times x, or two and a half times four  
23 dollars, would be ten dollars for the family. Now, this is not  
24 unusual because I think any of us who are acquainted with the  
25 cost curves in a pre-paid plan, or any insurance, for that



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1 matter, will find that in the first year of life it is a very  
2 expensive proposition and from there on up into the early  
3 teens it is relatively inexpensive, and on up even up into  
4 the late teens.

5           Then most carriers eliminate as a dependent those  
6 persons who have reached age 19; so in the early years their  
7 medical costs are relatively low, in comparison, to those in  
8 later years and this gives a break to those persons in the  
9 older age category who have no dependents, other than a man  
10 and wife, and they are paying only their premium for the two  
11 of them. For the parents, if the family are helping to carry  
12 theirs, if you carried this through to the ultimate, you would  
13 have a rate structure compounded many times over and above  
14 this, which was really not feasible.

15           MRS. AYLEN: Can I just come back to page 22  
16 again. This is something that just came to me now. What  
17 percentage of your subscribers avail themselves of the ability  
18 to have periodic check-ups? Can you tell me that? I do not  
19 expect a one hundred per cent accurate answer.

20           MR. WALPOLE: About 11.4 persons per thousand  
21 covered, per month.

22           MRS. AYLEN: That does not include any diagnos-  
23 tic service?

24           MR. WALPOLE: No, this is the routine medical  
25 check-up. If there were additional diagnostic service -- that



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expensive proposition and from there on up into the early  
teens it is relatively inexpensive, and on up even up into  
the late teens.

Then most carriers eliminate as a dependent those  
persons who have reached age 10; so in the early years, when  
medical costs are relatively low, in comparison, to those in  
later years and this gives a break to those persons in the  
older age category who have no dependents, other than a man  
and wife, and they are paying only their premium for the two  
of them. For the parents, if the family are helping to carry  
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MRS. AYIEN: Can I just come back to page 12  
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MR. WALPOLE: About 11.4 persons per thousand  
covered, per month.

MRS. AYIEN: That does not include any diagnosis  
or treatment.

MR. WALPOLE: No, this is the routine medical  
check-up. If there were additional diagnostic service -- that



1 is if the physician felt there should be an x-ray -- then that  
2 would be over and above that.

3 MRS. AYLEN: Even if it was in his own office,  
4 it would not be allowed?

5 MR. WALPOLE: If he were doing radiology, yes,  
6 it would be allowed.

7 MRS. AYLEN: It would be allowed?

8 MR. WALPOLE: Yes.

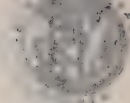
9 MRS. AYLEN: Thank you. That is all.

10 THE CHAIRMAN: Mr. Whitney?

11 MR. WHITNEY: I have just one question, Mr.  
12 Chairman. Mr. Walpole, on page 2 you discuss Schedule B and  
13 in your paragraphs 9 and 10, particularly in 9, you discuss the  
14 fall in enrolment under your plan from 1947 to 1959. Did you  
15 make a study of that block of business to know why this business  
16 did not get public acceptance so that you pretty much got out  
17 of it?

18 MR. WALPOLE: We found that at that time we were  
19 selling this small package, let us call it, limited type coverage,  
20 to groups of five or more and over a period of time our  
21 requirements for our comprehensive coverage changed. It was  
22 25 and then it dropped to 15 and 10 and our experience was that  
23 at the moment a group reached that size where they could request  
24 coverage in a comprehensive medical plan, this is what they did;  
25 so that we could not bring enough in at the top to keep pace





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MRS. AYLEN: It would be allowed?

MR. WALPOLE: Yes.

MRS. AYLEN: Thank you. That is all.

MR. WHITNEY: I have just one question, Mr.

Chairman. Mr. Walpole, on page 8 you discuss Schedule B and

in your paragraphs 9 and 10, particularly in 9, you discuss the

fall in enrollment under your plan from 1947 to 1949. Did you

make a study of that block of business to know why this business

did not get public acceptance so that you pretty much got out

MR. WALPOLE: We found that at that time we were

selling this package, let us call it, limited to a certain

to groups of five or more and over a period of time our

requirements for our comprehensive coverage changed. If

25 and then it dropped to 15 and 10 and our experience was that

at the moment a group reached that stage where they could reduce

coverage in a comprehensive medical plan, this is what they did

so that we could not bring enough in at the top to keep pace



1 with the exodus at the bottom.

2 MR. WHITNEY: Your suggestion of deletion then  
3 is to have the Schedule B in-hospital medical services under  
4 Schedule A?

5 MR. WALPOLE: Yes. We are not against any  
6 carrier selling coverage the equivalent of Schedule B; but we  
7 do not think it should be in the Act as a standard plan.

8 Mr. Chairman, may I correct a statement I made  
9 previously?

10 THE CHAIRMAN: Yes.

11 MR. WALPOLE: I made the statement to Mrs. Aylen.  
12 I quoted an 11.4 figure and I was reading a line too high. It  
13 is 2.9.

14 THE CHAIRMAN: That is 2.9 per thousand, per  
15 month?

16 MR. WALPOLE: That is right.

17 THE CHAIRMAN: Do you have further questions,  
18 Mr. Whitney?

19 MR. WHITNEY: In this withdrawal from the  
20 Schedule B type plan that we have been discussing, did it seem  
21 to make any difference to you, in your experience, whether the  
22 premium was fully paid by the employer or partly paid both ways  
23 by employer and employee?

24 MR. WALPOLE: When this plan reached its maximum  
25 proportion in 1957, at that time there was very little employer

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16 MR. WALPOLE: That is right.

17 THE CHAIRMAN: Do you have further questions?

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19 MR. WHITNEY: Is this withdrawal from the

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21 to make any difference to you, a

22 premium was fully paid by the employer or partly paid by

23 by employer and employee

24 MR. WALPOLE: When this plan reached its maximum

25 proportion in 1957, at that time there was very little employee





1 participation. So I would say that that did not have too much  
2 effect on it and as time went on this became more and more  
3 prevalent with the employer participation in the cost. I  
4 wouldn't say it didn't have any effect; but I would say, from  
5 our experience in 1947, when it reached its maximum at that  
6 time, this type of agreement did not become prominent in this  
7 area. I am talking about labour-managements agreements now.  
8 It came prominent in this area in the early '50's. About 1952,  
9 I would say, this became -- came into vogue at that time and  
10 our coverage in our limited plan was slipping at that time.  
11 So I would say that this was not the deciding factor.

12 THE CHAIRMAN: Mr. Coulter?

13 MR. COULTER: I would like to know what the  
14 procedure is or how you can handle it where you have a person  
15 employed in a group, who has enjoyed group coverage for a number  
16 of years and he becomes of retirement age, 65; what happens  
17 to him? Can he still carry on under the group coverage of his  
18 former employer or does he have to buy an off-street program  
19 and, if so, is there any difference in the rate?

20 MR. WALPOLE: There are two avenues of pursuit  
21 here. One is, as far as we as a corporation are concerned, we  
22 do not require that this man be dropped from his employer's  
23 coverage. He may continue to enjoy the group rate and the group  
24 benefits as he did throughout his working years, provided his  
25 employer will continue to keep him on his group. If the employer



participation in the group. It is not a requirement that the group must be present with the employer participation in the group. I wouldn't say it didn't have any effect; but I would say, our experience in 1947, when it reached its maximum, at that time, this type of agreement did not become prominent in 1952. It came prominent in this area in the early '50's. I would say, this became -- came into vogue at that time and our coverage in our limited plan was slipping at that time. So I would say that this was not the deciding factor. MR. COULDER: I would like to know what the procedure is or how you can handle it where you have employed in a group, who has enjoyed group coverage of years and he becomes of retirement age, 65; what to him? Can he still carry on under the group coverage? I think former employer or does he have to buy an individual program and, if so, is there any difference in the rates? MR. WALLACE: There are two avenues of here. One is, as far as we as a corporation are concerned, do not require that this man be dropped from his group coverage. He may continue to enjoy the group rate and the group benefits as he did throughout his working years, provided his employer will continue to keep him on his group. If the



1 does not see fit to extent that privilege to his employee, then  
2 we allow him to continue his exact same coverage, without any  
3 loss of waiting periods, at a rate which is slightly above  
4 group rate, enough to pay for the extra administration costs  
5 involved in handling him as an individual, as opposed to a  
6 group.

7 THE CHAIRMAN: Are there any further questions,  
8 Mr. Whitney?

9 MR. WHITNEY: Not at the moment, Mr. Chairman.

10 THE CHAIRMAN: Dr. Galloway?

11 DR. GALLOWAY: I have two very unrelated  
12 questions that I would like to ask and it is slightly due to  
13 my ignorance of Medical Carriers Incorporated and its future  
14 activities. It would appear to me that there will be a con-  
15 siderable number of carriers who will be associated with this  
16 organization. It is undoubtedly true also that there will be  
17 a great variation in the amount of business that they do. It  
18 would seem that Carriers Incorporated will have to deal with  
19 the various amounts of business, or various companies and, yet,  
20 you have suggested a flat rate of payment for each of these  
21 and you have given your reason on page 14, paragraph 43. It is  
22 slightly due to my ignorance of this, but if you could clarify  
23 it I would appreciate it.

24 MR. WALPOLE: I will do my best to clarify our  
25 position in this respect. It was not visualized that Medical



does not see fit to extend that privilege to his employee, then we allow him to continue his exact same coverage, without any loss of waiting periods, at a rate which is slightly above group rate, enough to pay for the extra administration costs.

THE CHAIRMAN: Are there any further questions?

MR. WHITNEY: Not at the moment, Mr. Chairman.

THE CHAIRMAN: Dr. Galloway?

DR. GALLOWAY: I have two very unneccessary

questions that I would like to ask and it is slightly due to my ignorance of Medical Careplans Incorporated and its various activities. It would appear to me that there will be a considerable number of members who will be associated with this organization. It is undoubtedly true also that there will be a great variation in the amount of business that they do. It would seem that Careplans Incorporated will have to deal with the various amounts of business, or various companies and, yet you have suggested a flat rate of payment for each of these and you have given your reason on page 14, paragraph 48. It is slightly due to my ignorance of this, but it

it I would appreciate it.

MR. WALBORN: I will do my best to clarify our

position in this respect. It was not envisioned that Medical



1 Carriers Incorporated will ever become insuring agents them-  
2 selves. They will never pay claimants. It will be, to put  
3 it in simple terms, a clearing-house. The carrier will report  
4 his gross figures, his statistics, as required by M.C.I., in  
5 order for them to put him in his proper niche or to relate his  
6 experience with that of all carriers. One of the duties of  
7 Medical Carriers Incorporated, which we have enunciated in our  
8 brief, will be to declare and regulate open enrolment periods.  
9 The open enrolment period, it is no more of a problem for  
10 Medical Carriers Incorporated to say that we will have an open  
11 enrolment period from October 1st to November 30th and P.S.I.,  
12 which I believe is the largest single carrier in the Province  
13 of Ontario -- it is no greater chore for M.C.I. to say that  
14 than it is to say to the railway -- not the brotherhood -- the  
15 gentlemen who were here this morning, the nine hundred persons  
16 -- it is still from October 1st to November 30th. This is a  
17 rather simple way of putting it. There are other considera-  
18 tions. When you get into the dollar value and each carrier  
19 will report through his total and when you get into a pooling  
20 arrangement, his total claims cost for those persons who are  
21 pooled, and the only difference between the fellow with the  
22 nine hundred and the fellow with a million will be the number  
23 of digits to the left of the decimal point. So, basically, they  
24 are doing the same thing for both, or at least, M.C.I. is.

25 MR. COULTER: Did you have any formula to produce

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his gross figures, his statistics, as required by M.C.I., in  
it in simple terms, a clearing-house. The carrier will report  
selves. They will never say claimants. It will be, to put





1 this flat rate?

2 MR. WALPOLE: Pardon?

3 MR. COULTER: Did you have any formula to  
4 produce this flat rate?

5 MR. WALPOLE: Well, I would have to say this:  
6 I do not think anyone, to my knowledge, has any idea of the  
7 expenses involved in the operation of M.C.I. until it becomes  
8 an operating unit.

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dpw 1 DR. GALLOWAY: Could you give us a guess as to  
2 whether such an organization as was here this morning, the  
3 Railroad Hospital Association, would such an organization be  
4 able to pay on the same basis as P.S.I.?

5 MR. WALPOLE: Well, again, we get back to what  
6 the value of X would be, what we are going to apportion out.

7 Let's take a very simple proposition here, and  
8 let's say that it's going to cost an organization \$600. That's  
9 \$2 a year for each person they have got covered. I'm sorry, I'm  
10 getting ahead of myself. If they're going to pay \$600, they  
11 have to charge 50 cents a year if they have 1,200 people there,  
12 and if you average that over a per-month cost, it isn't going  
13 to be too hard on the small carrier. But we don't know what  
14 X is going to be, and that's one of the reasons why I can't  
15 give you a straightforward answer on it, sir.

16 DR. GALLOWAY: Thank you very much. I have  
17 another question, which is completely unrelated, but it does  
18 have to do with the briefs which have already been presented  
19 to us, one from the podiatrists, and one from the chiropractors,  
20 each of whom have requested that their services be insured  
21 under whatever plan is introduced by government.

22 In the event that these services became  
23 insurable under the standard plan, could you, as an Association,  
24 insure them, and if you could, what problems would it create  
25 for you?

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1 MR. WALPOLE: May I sort of break your question  
2 down just a little?

3 First, you can't add any item of service, or  
4 extend benefits in any way, shape or form, without incurring  
5 additional costs. This is something that just doesn't  
6 happen. So, immediately you introduce something like this,  
7 you introduce an element of cost.

8 This is one problem which would be created.  
9 Then, if we were to embrace these other services which aren't  
2 10 currently covered, and honestly I would have to think a little  
11 further along those lines to really give you an answer as to  
12 the problems that might be involved in covering those two.

13 DR. GALLOWAY: Well, one of the things that  
14 you might be able to answer is, would this require any change  
15 in your charter?

16 MR. WALPOLE: Yes, it would. As far as we are  
17 concerned it would require a change in our agreements, because  
18 at the moment we're precluded from paying anything other than  
19 the services of a legally-qualified medical practitioner under  
20 The Medical Act.

21 DR. GALLOWAY: Thank you very much.

22 MR. CASWELL: Mr.Chairman, I'd like Mr. Walpole,  
23 to ask you one question further on page 22, Section 65, which  
24 has already been spoken to.

25 I think that I agree with you that an annual

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MR. GOSWELL: Mr. Chairman, I'd like Mr. Waipole.

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MR. WAIPOLE: May I ask of please your question



1 health examination, in the long term, would be good for the  
2 patient, as well as, perhaps, the Medical Association. I'm  
3 interested in knowing whether you believe, first of all, that  
4 the medical profession could cope with an annual health examina-  
5 tion, if everyone were covered with health services?

6 MR. WALPOLE: Mr. Chairman, I would like to  
7 refer that question to one of my confreres here, and I would  
8 ask our President if he would take that question.

9 THE CHAIRMAN: Granted.

10 DR. DUROCHER: Well, I think in answer to that  
11 question, in terms of my own experience here, where you have  
12 quite a large segment of the population covered, and the  
13 medical profession here is coping ---

14 MR. CASWELL: I thought you suggested that only  
15 2.9 persons per thousand per month were having this periodic  
16 inspection, which seems to be quite a small number, is it not,  
17 in your case?

18 If this were included in the Act, I would assume  
19 from the very fact that you brought it up that you would  
20 recommend that this be a condition of coverage, that everyone  
21 would, as a condition of their contract, have an annual examina-  
22 tion?

23 DR. DUROCHER: That seems to be the general  
24 fear, but our own experience doesn't show it.

25 MR. CASWELL: You mean you don't make it



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MR. CASWELL: You mean you don't make it





1 conditional to the contract?

2 DR. DUROCHER: No.

3 MR. CASWELL: But are you not suggesting such  
4 a thing?

5 MR. WALPOLE: All we're suggesting here, sir,  
6 is that this would be a benefit. We're not suggesting that  
7 it would be a compulsory examination. It would be a benefit,  
8 the same as an appendectomy.

9 MR. CASWELL: If it is good, and this Act is  
10 for the good of humanity, why should it not be covered?

11 MR. WALPOLE: Well, there are several Acts  
12 that you could apply that same criterion to, and I would hate  
13 to see one phase of medical services become a compulsory item  
14 when, perhaps, you could be just as justified in making some  
15 other area of medical services compulsory.

16 MR. CASWELL: Then by including this you're  
17 only going to give the benefit to the very small percentage  
18 who would take advantage of it?

19 MR. WALPOLE: I might clarify that in this  
20 respect. In our organization we have included periodic health  
21 examinations. As I explained earlier, each person covered in  
22 our plan, after he has fulfilled the initial waiting periods,  
23 is eligible for medical examination every twelve months, or  
24 at least there must be a twelve-month lapse between the exami-  
25 nations.

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nations.



1 Now, if he is receiving regular medical care  
2 from his doctor, then he's not eligible for it. At least, we  
3 do not pay the physician for that, because this is not preven-  
4 tive medicine.

5 MR. WHITNEY: Do you have salesmen in the field?

6 MR. WALPOLE: We've had two until very recently,  
7 and we only have one now.

8 THE CHAIRMAN: Does that complete your ques-  
9 tioning, Mr. Caswell?

10 MR. CASWELL: Thank you, sir.

11 THE CHAIRMAN: Mr. Simon?

12 MR. SIMON: On page 1, Mr. Walpole, you speak  
13 about "off-the-street" enrolment, or the non-group enrolment.

14 Do you charge these people a different premium  
15 than you do the groups?

16 MR. WALPOLE: Yes.

17 MR. SIMON: You do?

18 MR. WALPOLE: Yes.

19 MR. SIMON: Is it much higher?

20 MR. WALPOLE: To give you an exact figure on  
21 that, the single rate with group is \$3.25 to a person per  
22 month, and the pay direct, that is the group conversion, is  
23 \$3.60, and the non-group is \$3.85.

24 MR. SIMON: On page 5, paragraph 18, you're  
25 making recommendations that the Act be changed to read that

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MR. SIMON: On page 1, Mr. Walpole, you speak

about "off-the-street" enrolment, or the non-group enrolment.

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than you do the groups?

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MR. WALPOLE: To give you an exact figure on

that, the single rate with group is \$2.25 to a person per

month, and the pay direct, that is the group conversion, is

\$3.60, and the non-group is \$3.85.

MR. SIMON: On page 5, paragraph 18, you're

making recommendations that the Act be changed to read that





1 people that have mis-used the services be denied coverage, and  
2 so on.

3 How can any person mis-use the services without  
4 a doctor being involved in it?

5 MR. WALPOLE: I think that's very easily  
6 explained, sir. We have in our experience on a couple of  
7 different occasions found a particular individual who was  
8 seeing three doctors, three general practitioners, in one day  
9 for no particular ailment at all.

10 I think this is a real abuse of service.

11 MR. SIMON: Do you get that in Toronto?

12 MR. WALPOLE: I don't think we would want to  
13 inflate the cost of medical care in this province by allowing  
14 that to continue.

15 MR. SIMON: Wouldn't you say that the wording,  
16 the way you have it, can be widely interpreted, misinterpreted?

17 MR. WALPOLE: I would like to point out that  
18 we have used the words:

19 "---or proven continued mis-use of services---"

20 I could subscribe that that particular individual might have  
21 on occasion found it necessary to visit two doctors on the  
22 one day. Perhaps one doctor wasn't available for some reason  
23 or other, but we've put in the word "continued" here, and  
24 simply because it happens once doesn't mean it's a mis-use  
25 of services, but if this thing persists, I think you have a

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1 good case.

2 MR. WHITNEY: Is it in your contract now, this  
3 mis-use of service?

4 MR. WALPOLE: Not as such, no, but we do have  
5 the right within our agreement to terminate the coverage of  
6 any individual.

7 MR. SIMON: On page 21 you're making suggestions  
8 with regards to the set-up of arbitration with regard to the  
9 difference of rates and so on. You are still suggesting that  
10 two of the representatives of the Board of Arbitration be  
11 from the carriers in different categories, and one be an  
12 impartial representative named by a judge from the Supreme  
13 Court.

14 Now, where, in your view, does the public come  
15 in, that has to pay the bill after all, on the set-up of the  
16 determination of what is to be a proper rate?

17 MR. WALPOLE: Well, I would say that this applies  
18 only to the maximum subscription rate, and the vast majority of  
19 the public will never be involved in it.

20 MR. SIMON: Somebody told us this morning that  
21 eventually everybody will be paying the maximum subscription.

22 MR. WALPOLE: Well, I would only have to say  
23 that perhaps that individual expressed an individual point of  
24 view, and I express my own, that this will not be affected.

25 MR. SIMON: You talk about comprehensive

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1 coverage, and I'd like to know if your organization has ever  
2 made a survey in the area here about what actually it does  
3 cost a family to cover all their insurance, other than what  
4 you provide for them?

5 MR. WALPOLE: No, we've never made such a survey.

3 6 THE CHAIRMAN: Do any other members of the  
7 Enquiry have questions that they wish to direct to this dele-  
8 gation?

9 DR. BUTT: On the constitution of Medical  
10 Carriers Incorporated, as you heard this morning, there are  
11 several other organizations, and probably a number of others  
12 who might want representation, and as I read it, there's no  
13 provision for that.

14 MR. WALPOLE: In what we've set up for the  
15 moment for Medical Carriers Incorporated?

16 DR. BUTT: Yes; and the other question related  
17 to it today. This is just another little formula, and you  
18 say two from the insurers, one P.S.I., one W.M.S., and one  
19 from the others.

20 Is this a compatible group? In other words,  
21 your Medical Carriers Incorporated becomes a five-man group?  
22 This is on page 13, Section 41.

23 MR. WALPOLE: Is that not seven?

24 DR. BUTT: No. Two from carriers, one P.S.I.,  
25 being the heaviest, and one W.M.S., whether they are



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DR. BUTT: No. Two from carriers, one F.S.I.,  
MR. WALLACE: Is that not seven?

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1 compatible or not together, and then all the others. I  
2 think this works out relatively covering the same number, so  
3 that's five.

4 I'm just suggesting a possible formula, whether  
5 this would be good, bad, or indifferent.

6 Would that meet with your approval at all?

7 MR. WALPOLE: You're suggesting five instead  
8 of seven. Is this correct?

9 DR. BUTT: That's right, with that make-up.

10 MR. WALPOLE: And your question, again, is  
11 would this tend to improve the situation?

12 DR. BUTT: Would it be satisfactory to you?

13 MR. WALPOLE: No, I don't think so. I think  
14 that our feeling is that it should be just the way it's in  
15 here.

16 DR. BUTT: On page 22, Section 63, does this  
17 produce the responsibility, and I'm not quite sure at the  
18 moment, the responsibility would be somewhat on the carriers  
19 as to whether there's double coverage or not, and you want it  
20 reworded so that the responsibility lies with the individual?

21 MR. WALPOLE: That's right.

22 DR. BUTT: Well, what happens if he was  
23 mistakenly sold two or three policies? In other words, he  
24 might buy them in good faith. I don't know why, but he might.  
25 He might be sold them in good faith.



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1 MR. WALPOLE: As I recall Section 20 of the Act  
2 here, I believe the first policy registered is the one that  
3 takes precedent, I believe, if I recall it, and that's the  
4 only way I could see to get out of that.

5 Now, we're not lawyers, and we did not have  
6 legal opinion on this particular section of the Act. All we  
7 desired to do was to point out a problem here, which I believe  
8 only the legal profession can resolve, as to putting it into  
9 the correct wording, and we're just pointing out the problem.

10 DR. BUTT: Yes. Well, I realize the problem.  
11 I was trying to shift it back on the companies, instead of on  
12 the poor individual subscriber who might be gypped out.

13 MR. MULROONEY: W.M.S. covers a good proportion  
14 of the residents of Windsor and its suburbs. I'm wondering  
15 whether its coverage provides full payment for the services?  
16 Is the doctor permitted to charge in excess of the payments  
17 made by W.M.S.?

18 MR. WALPOLE: Mr. Chairman, this is a very  
19 interesting point. Windsor Medical Services has closed-end  
20 agreements with its participating physicians, and the only  
21 time a physician is allowed to extra-bill over and above the  
22 payment he receives through the Windsor Medical Services is in  
23 those areas where the annual income of that particular sub-  
24 scriber exceeds the income limits, which are \$7,000 annual  
25 income single, and \$10,000 annual income married.

MR. WALPOLE: As I recall Section 50 of the Act

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1 MR. MULROONEY: On page 4, in your recommenda-  
2 tion with regard to the definition of "benefit," you ask for  
3 the addition of the words "or on behalf of."

4 I wonder if this could not be satisfactorily  
5 handled in the contract that is issued to the applicant,  
6 provide for it there, and whether it's necessary to make any  
7 amendment?

8 MR. WALPOLE: We have a lot of these in our  
9 general population, curbstome lawyers, and if they got this  
10 Act they would sure wave it in front of you and say, "This  
11 means that this payment can't be made to anyone else except  
12 me," and service plans, of which Windsor Medical is one, we've  
13 traditionally made our payment direct to the doctor, and this  
14 gives us our opportunity to do that, to make payment on behalf  
15 of a covered person directly to his physician.

16 MR. MULROONEY: I've no further questions.  
17 That's the answer I expected.

18 MRS. AYLEN: In a city such as this you must  
19 have people who become unemployed while they are subscribers  
20 to your plan, and they might find it necessary to let their  
21 subscription lapse.

22 Is there any machinery set up to aid them?

23 MR. WALPOLE: Yes. First of all, let me deal  
24 with the person in this area, in this particular area, under  
25 negotiated contracts through employer and employee negotiation,



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I wonder if this could not be satisfactorily handled in the contract that is issued to the applicant, provide for it there, and whether it's necessary to make any

MR. WALPOLE: We have a lot of these in our general population, corporate lawyers, and if they got this Act they would sure wave it in front of you and say, "This means that this payment can't be made to anyone else except me," and service plans, of which Windsor Medical is one, we've gives us our opportunity to do that, to make payment on behalf of a covered person directly to his physician.

MR. MURDOCK: I've no further questions. That's the answer I expected.

MRS. AYLMER: In a city such as this you must have people who become unemployed while they are subscribers to your plan, and they might find it necessary to let their subscription lapse.

Is there any machinery set up to aid them?

MR. WALPOLE: Yes. First of all, let me deal

negotiated contracts through employer and employee negotiation





1 and many of these contracts now provide that this may be  
2 continued by the employer for a period of time, the month  
3 in which layoff takes place, for any period of time up to  
4 three months, and then he may - and I might say we have had  
5 instances where it has gone beyond that, it has gone beyond  
6 the contractual obligation, then he may elect to pay the  
7 employer the group rate to get advantage of the lower rate,  
8 and he will again remit through to us.

9 Now, this takes care of the chap who is laid  
10 off by an employer who has a negotiated contract.

11 The chap who doesn't have a negotiated contract,  
12 and have these inherent benefits, the only thing we can offer  
13 to him is a pay-direct agreement, and, of course, we can't  
14 provide coverage for anyone without receiving money for that  
15 particular month, but we do have a policy where if for some  
16 reason such as you outline a person very reluctantly is called  
17 upon to drop the coverage due to financial embarrassment, that  
18 if they apply to us within a six-month period -- we don't  
19 reinstate the contract, but we will give them a new contract  
20 without having to go back through the non-group agreement, and  
21 so on, such as they had before.

22 MR. MAJOR: Mr. Walpole, on page 4, you have  
23 referred to dependants, and it would appear to me that you've  
24 left out a couple of points that I would like to clarify.

25 You say that a dependant shall be "a son or

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MR. MAJOR: Mr. Walpole, on page 4, you have

referred to dependants, and it would appear to me that you've  
 left out a couple of points that I would like to clarify.  
 You say that a dependant shall be "a son or



1 daughter, or stepson or stepdaughter of the head of a family--"

2 Can you tell me what you are going to do, or  
3 how you're going to handle a grandchild, who's only visible  
4 support is grandfather?

5 MR. WALPOLE: Well, first I would like to go  
6 back to the wording of the Bill 163 in this particular  
7 section, and Section 1, sub-section (d), sub-sub-section (ii):

8 "any unmarried child under the age of 19  
9 years who is dependent or substantially  
10 dependent for maintenance upon the head  
11 of a family."

12 Now, it seems to me that this is a pretty broad  
13 platform on which to start to make a decision. It says:

4 14 "any unmarried child ---"

15 It doesn't say whether it's related, unrelated or not - "any  
16 unmarried child," a neighbour's, or anybody's else.

17 So we feel this must be taken care of by a  
18 change, and the change we've reflected in our submission here,  
19 and our thinking ran along these lines. It's much easier to  
20 write this on a reasonably tight basis, and administrate on  
21 those individual cases such as you outlined, and I don't mean  
22 this in a true sense, but administrate on a loose basis,  
23 rather than write it on a loose basis and try to administer  
24 it tightly.

25 MR. SIMON: I thought you told us before that

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1 you weren't lawyers.

2 MR. WALPOLE: Thank you.

3 MR. MAJOR: I understand what you're getting  
4 at, but I'm not too sure that the Government, the politician  
5 will accept this nebulous area of give, rather than take away.

6 Now, what are you going to do about this child  
7 who is 29 years of age, and can't work because of physical  
8 infirmity, where it says in the sub-paragraph (iii) of (d) --  
9 are you just going to eliminate this fellow, too?

10 MR. WALPOLE: No, we have him covered over on  
11 page 5, under sub-section (b).

12 Did I understand you to say 29 years of age?

13 MR. MAJOR: Yes.

14 MR. WALPOLE: Well, if he was 19 years of age,  
15 or older, mentally or physically infirm, and dependent for  
16 support on the head of the family or upon the spouse of the  
17 head of the family before his 19th birthday but that does not  
18 include the spouse or dependants of any such child.

19 MR. MULROONEY: May I observe, Mr. Chairman,  
20 that such a person would probably qualify for the disabled  
21 persons' allowance, and should be a government responsibility  
22 then.

23 THE CHAIRMAN: Remember that we're not debating  
24 this issue.

25 MR. MAJOR: Mr. Walpole, on page 8 you are

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this issue.

MR. MAJOR: Mr. Walpole, on page 8 you are



1 referring to Section 4 of the Act, and the only change I see  
2 is that you have eliminated the wording "or standard in-hospital  
3 medical --" but I'd like to ask you about the wording "a local  
4 municipality may."

5 Do you think it's proper that a municipality  
6 should have an election in this issue?

7 MR. WALPOLE: If I might just ask for a little  
8 clarification, Mr. Major. What you're saying, if I interpret  
9 it correctly, is, should a municipality have the right to say,  
10 "We will pay the medical costs of this particular indigent if  
11 those costs are likely to be less than the premium which we  
12 would pay if we covered him under this type of program."

5 13 MR. MAJOR: That's right. I'm asking the ques-  
14 tion, Mr. Walpole, because we've had several references to  
15 anti-selection.

16 MR. WALPOLE: Will you pardon me just one  
17 moment while I read the previous ---

18 I'd say that Mr. Major has put his finger on a  
19 good point here, that this could leave itself open to an abuse  
20 by anti-selection. It might well be that the municipality  
21 shouldn't have that option.

22 I think, looking at it now I would say that.

23 MR. MAJOR: Mr. Walpole, on page 13, I was very  
24 interested in a recommendation you set forth here:

25 "We recommend that each director be a

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1 permanent resident of the Province of  
2 Ontario."

3 Supposing that we had a very knowledgeable chap  
4 on medical economics living in Montreal, but that from a  
5 technical standpoint it would be very desirable to have him  
6 on this Board; would you want to eliminate the privilege of  
7 having this chap on this Board?

8 MR. WALPOLE: If this chap is a very knowledge-  
9 able chap living in the City of Montreal, or anywhere else,  
10 for that matter, I think we could even go beyond that. Let's  
11 go to another country. If he is that valuable, I am sure that  
12 a representative on this Board could seek his advice on a parti-  
13 cular problem, and it would still -- his wealth of knowledge  
14 could still be utilized in that particular field, and yet we  
15 would be keeping this within the confines of the Province of  
16 Ontario, because this is an Act developed by the Province of  
17 Ontario for the citizens of this particular province, and  
18 simply because this chap lives outside of the province doesn't  
19 preclude us from seeking advice from that particular individual.

20 MR. MAJOR: In other words, you would use him as  
21 a consultant?

22 MR. WALPOLE: That's right.

23 MR. MAJOR: But you wouldn't necessarily  
24 shoulder him with a responsibility that he isn't living with,  
25 as it were?

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as it were?



1 MR. WALPOLE: That's true.

2 MISS McARTHUR: I'm wondering if there have  
3 been any problems regarding the care of the newborn, and  
4 whether the problem has necessitated the writing of regulations  
5 thereon, or has it not been a problem at all?

6 MR. WALPOLE: We do cover newborn care.

7 DR. ROEMMELE: I don't exactly understand the  
8 question, Mr. Chairman. Newborn care is covered in our  
9 contract, a certain number of visits are outlined that they  
10 are eligible for.

11 MISS McARTHUR: I was referring to page 26,  
12 removing the examination from the Act and leaving it to be  
13 controlled by the O.M.A. Schedule, and in addition to that  
14 having had to write regulations.

15 MR. WALPOLE: We have certain limits on well-  
16 baby care visits, and this particular examination which we  
17 have mentioned here should be controlled by the fee schedule.  
18 This is really a benefit. It isn't something which should be  
19 in the Act.

20 MR. SIMON: What proportion of the doctors in  
21 this area are participants in the Windsor Medical Services?

22 MR. WALPOLE: About 98%, sir.

23 MR. SIMON: In case of a strike at one of the  
24 companies that has insurance with your people, do you allow  
25 the union to pay the premiums for the group?



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thereon, or has it not been a problem at all?

whether the doctor has a separate fee schedule or whether

from any problems regarding the fee schedule?

MISS McARTHUR: I'm wondering if there have

MR. WALPOLE: Yes, sir.





1 MR. WALPOLE: Yes, they pay it through the  
2 company, so that all persons -- there are certain classifica-  
3 tions of employees not considered to be on strike, and they'll  
4 be covered, but our arrangement has been in the past that the  
5 union pays through the company.

6 MR. SIMON: And no one loses any benefit?

7 MR. WHITNEY: Do you allow any grace period  
8 before you terminate, or lapse a contract for non-payment of  
9 premium?

10 MR. WALPOLE: Yes, first of all those persons  
11 terminating from a group have a 30-day period in which to pick  
12 up their pay-direct agreement.

13 MR. WHITNEY: Thirty clear days?

14 MR. WALPOLE: Yes, 30 days from the end of the  
15 paid-up period on the group. They have 30 days to pick up  
16 their pay-direct agreement, or the group conversion.

17 Then those persons billed on non-direct, or  
18 pay-direct agreement are billed roughly on the 20th of the  
19 month, or the due date of the first of the following month,  
20 but we continue to carry those people along till the last day  
21 of that month. In other words, they have 30, 31 days of grace.

22 MR. WHITNEY: Do you send out a notice of termi-  
23 nation?

24 MR. WALPOLE: No, it's done, or I should say,  
25 yes, we do, to a degree.



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1 Those persons terminating from a group are  
2 all notified. Those persons who have allowed their coverage  
3 to lapse into this 30-day period of grace, when we come up to  
4 the next billing cycle we double-bill them then, and if they're  
5 not paid at the end of the month they get a special billing,  
6 telling them it will be cancelled.

7 MR. WHITNEY: That's included in the double-  
8 billing?

9 MR. WALPOLE: That's right. So that in effect  
10 everyone gets notice.

11 MR. WHITNEY: How about reinstatement? If the  
12 individual doesn't pay his premium for some period of one, two  
13 or three months, do you allow reinstatement, or is it a new  
14 application? Do you have any clause in your contract?

15 MR. WALPOLE: No, there's no clause in the  
16 contract. This is administered by administration on the basis  
17 of there are extenuating circumstances in a number of cases,  
18 and these are reviewed, and if the case warrants reinstatement,  
19 or full reinstatement of all benefits, then that is done. If  
20 it doesn't, then they are offered a new course.

21 MR. WHITNEY: Do you have rules and regulations  
22 as to when you will exercise your discretion, and how?

23 MR. WALPOLE: I don't quite follow your ques-  
24 tion.

25 MR. WHITNEY: Well, this is a discretionary





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all notified. Those persons who have allowed their coverage  
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MR. WHITNEY: How about reinstatement? If the

individual doesn't pay his premium the same period of time, two  
or three months, do you allow reinstatement, or is it a new  
application? Do you have any clause in your contract?

MR. WALPOLE: No, there's no clause in the

contract. This is administered by the Insurance Co. of the State  
of there are extenuating circumstances as a matter of fact,  
and these are reviewed, and if the state permits reinstatement,  
to full reinstatement of all benefits, then that is done. It  
is usually, then they are offered a new contract.

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as to when you will exercise your discretion, and what

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MR. WHITNEY: Well, that is a discretionary





1 power you are exercising?

2 MR. WALPOLE: Yes.

3 MR. WHITNEY: And I imagine the power is vested  
4 in a committee of your organization?

5 MR. WALPOLE: Yes, and this can go right on up  
6 to our Board of Directors.

7 MR. WHITNEY: Do you have any written bylaws,  
8 or rules and regulations, as to when you consider it is a  
9 deserving case, and when non-deserving?

10 MR. WALPOLE: Not as written law, no.

11 MR. WHITNEY: Do you make your payment having  
12 the bill from the doctor rendered direct to you, or do you  
13 have the patient fill out a form?

14 MR. WALPOLE: No, the doctor renders his  
15 account directly to Windsor Medical Services.

16 MR. WHITNEY: Is there anything in your  
17 contract, or in what you have your medical doctor membership  
18 supply in the way of a bill with -- I think it would be in the  
19 contract, really. Is there anything in your contract of these  
20 words "on behalf of" that we've been talking about, stating  
21 that you have the right to pay to the doctor on behalf of the  
22 insured?

23 MR. WALPOLE: It's implied in here. It's  
24 really in reverse. It is only when the subscriber is travel-  
25 ling on vacation, or business, that we make any agreement to

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1 pay anything to him.

2 MR. WHITNEY: To the subscriber?

3 MR. WALPOLE: That's right.

4 MR. WHITNEY: These words you are suggesting  
5 might usefully go into the Act. Do you have any such words  
6 in your contract?

7 MR. WALPOLE: No.

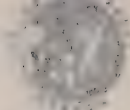
8 MR. MAJOR: Mr. Walpole, it's common in some  
9 insurance contracts to insert words of this kind: "That non-  
10 payment is automatic cancellation of this agreement."

11 Do you exercise this? You've told us that you  
12 send out two or three notices, but when you are finished with  
13 that, and this is done, this is a cancellation because they  
14 didn't pay the bill?

15 MR. WALPOLE: That's right. "Failure to pay  
16 the subscription rates applicable shall entitle the corpora-  
17 tion to automatically terminate the provisions of the agreement  
18 created hereby and any benefits accruing thereunder and it is  
19 specifically declared that time shall be of the essence of the  
20 provision for payment of all such subscription rates."

6 21 MR. MAJOR: Have you provision in your agree-  
22 ment of appellate authority that a subscriber can appeal to,  
23 other than you as General Manager, or as Administrator?

24 MR. WALPOLE: Yes, it's not in the agreement  
25 that he can appeal to the Board of Directors.



1 THE CHAIRMAN TO HIM.

2 MR. WHITNEY: To the subscribers?

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25 that he can appeal to the Board of Directors.





1 MR. MAJOR: Is it in your charter?

2 MR. WALPOLE: It's not in the charter either,  
3 but this is one of those things which has become a part of our  
4 way of life, that anyone can appeal to the highest authority  
5 within our organization, which is our Board of Directors.

6 MR. MAJOR: Considering Bill 163 in toto, would  
7 you accept the statement that this Bill will expect a carrier  
8 to recognize psychiatric services without limit?

9 MR. WALPOLE: I think this is definitely  
10 implied in Schedule A.

11 MR. MAJOR: You think this is a reasonable  
12 thing for this Bill to require?

13 MR. WALPOLE: In terms of dollars, I think this  
14 is going to lead us into a very inflationary aspect of medical  
15 care, if we are called upon to pay psychiatric services in  
16 toto, which are now being performed in provincially-admini-  
17 stered hospitals, with psychiatrists working in those hospitals,  
18 who aren't working on a fee-for-service basis, and to  
19 suddenly throw this load into the arena of Bill 163 I think  
20 can only ask for chaos from the dollar standpoint.

21 MR. MAJOR: This, of course, will be quite a  
22 discussion in this Enquiry some day.

23 You have made no recommendation regarding this  
24 aspect of this Bill in your submission. Would you help us out  
25 now by giving us your opinion as to whether or not it would be



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MR. MAJOR: That, of course, will be quite a

discussion in this Agency some day.

You have made no recommendation regarding this

aspect of this Bill in your submission. Would you help us out

now by giving us your opinion as to whether or not it would be



1 reasonable to at least consider the launching of this Bill  
2 with a limitation for psychiatric care?

3 MR. WALPOLE: Yes, I think this Bill could be  
4 enlarged to embrace a certain amount of psychiatric care  
5 rendered on a fee-for-service basis, but I think, in order to  
6 avoid the chaos which I mentioned earlier, that this would have  
7 to be limited to a specific number of treatments, or number of  
8 hours' care in a given period of time, and if we're to take the  
9 data supplied by the psychiatric section of the organized  
10 medicine it would seem that 50 hours per year, I believe, if  
11 I recall the figures correctly, they thought would amount to  
12 somewhat in the neighbourhood of twelve million dollars a year,  
13 and this is a sizeable chunk of money for a limited program.

14 So, I can only say if we apply this for a  
15 limited program, where would it leave us on a wide-open  
16 program?

17 MR. MAJOR: Thank you. If you will refer to  
18 Schedule A, the exceptions. Annual periodic health examina-  
19 tions, under 1. Under 5, it says:

20 "Services with respect to conditions that  
21 do not interfere with the covered person's  
22 bodily functions, or with respect to treat-  
23 ment for cosmetic purposes."

24 Now, considering these, would you say that this  
25 Bill included well-baby care?

reasonable to at least consider the financing of this Bill with a limitation for psychiatric care?

MR. WALPOLE: Yes, I think this Bill could be

enlarged to embrace a certain amount of psychiatric care rendered on a fee-for-service basis, but I think, in order to avoid the chaos which I mentioned earlier, that this would have to be limited to a specific number of treatments, or number of hours' care in a given period of time, and if we're to take the data supplied by the psychiatric section of the organized medicine it would seem that 50 hours per year, I believe, is I recall the figures correctly, they thought would amount to somewhat in the neighbourhood of twelve million dollars a year, and this is a sizeable chunk of money for a limited program. So, I can only say if we apply this for a

limited program, where would it leave us on a wide-open

MR. MAJOR: Thank you. If you will refer to Schedule A, the exceptions. Annual periodic health examinations, under 1. Under 5, it says:

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1 MR. WALPOLE: I would say you could interpret  
2 "annual or periodic health examinations," if you so desired,  
3 as well-baby care, or at least interpret well-baby care as a  
4 periodic health examination. It might be once a month, but it  
5 could be interpreted to that exception, and again, as you  
6 point out in 5:

7 "Services with respect to conditions that  
8 do not interfere with the covered person's  
9 bodily functions, or with respect to treat-  
10 ment for cosmetic purposes."

11 Well-baby care, again, could be excluded under  
12 the first part of No. 5.

13 MR. MAJOR: Well, I'm struck by the paradox,  
14 Mr. Walpole, that you have suggested in your submission that  
15 we have well-adult care, because that is what a periodic  
16 physical examination is, this is well-adult care, but you  
17 haven't commented as to whether or not we should have well-  
18 baby care.

19 MR. WALPOLE: Well, I think, Mr. Chairman, in  
20 reply to Mr. Major's supposition there, I think he has read  
21 into our submission something which really it didn't contain.

22 We said that there should be annual or periodic  
23 health examinations, which could be interpreted to mean well-  
24 baby care, but we have not applied the connotation "adult" to  
25 it.



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1 MR. MAJOR: Well, let me go one step further,  
2 then, and I know this is not in your submission, but we're  
3 interested in these kinds of things.

4 Supposing that it's decided that well-baby care  
5 is a normal benefit of this agreement, which, in my opinion,  
6 and it's got nothing to do with the Enquiry, it is not,  
7 because of these exceptions and the way they are written,  
8 and no submission we have dealt with yet has brought this  
9 point out, but supposing that this does become a benefit of  
10 this agreement, with maybe some help from the professional  
11 people, it is my opinion that a baby includes the years of  
12 from the time it is born till the time it is 14, I believe.

13 If this agreement is going to cover well-baby  
14 care, would you consider that well-baby care should go through  
15 14 years of life; the first 14?

16 DR. ROEMMELE: Mr. Chairman, Mr. Walpole has  
17 asked me to answer this. I don't know exactly what Mr. Major  
18 is driving at. We call well-baby care up to a year, and after  
19 a year they are infants, and children, and, as you know very  
20 well, once your medical does cover well-baby care there's a  
21 certain stipulated number of visits in the first and each  
22 succeeding years, and we do allow an annual examination on a  
23 child at a little less rate than on an adult, and we certainly  
24 did not imply to exclude well-baby care from our recommenda-  
25 tions.



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1                   This is something that none of us thought any-  
2 one would read into it. In our recommendations we certainly  
3 mean to imply that well-baby care should be part of the  
4 standard medical services contract.

5                   MR. MAJOR: Thank you. That's the point I  
6 wanted to bring out.

7                   DR. GALLOWAY: These questions have been so  
8 interesting. Mine is a very minor and almost likely not one  
9 that should be delivered here. It so happens that if this Act  
10 goes through, the double coverage won't be allowed and it may  
11 not be as true in this area because there is only one major  
12 insurance company and that is Windsor Medical Services. However,  
13 in other areas there are men and women working in different  
14 institutions, one of whom will be covered by one insuring com-  
15 pany and another by another company. What will you do about  
16 the premiums for the individuals who are under a group coverage  
17 on this basis?

18                   MR. WALPOLE: I do not think that we can get  
19 into an area which is, perhaps, a negotiated contract between  
20 employer and employee and expect to be able to write an Act or  
21 write regulations that will govern all these things. So, in  
22 my humble opinion, these people are going to have to get  
23 together some way or other and get double coverage on there.  
24 That might sound sort of a confused statement. But we do  
25 encounter double coverage in this area, somewhat on the basis

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1 which you outlined, and employers have gotten together and  
2 ironed this thing out. And I see no reason why we should set  
3 up machinery to take care of something which is a Frankenstein  
4 in your own name.

5 MR. WHITNEY: Do you allow double coverage in  
6 your contracts?

7 MR. WALPOLE: Yes.

8 MR. SIMON: Do you allow portability from one  
9 group to another within your own organization? I refer to  
10 waiting periods?

11 MR. WALPOLE: Yes. They never lose their waiting  
12 periods, provided that they have paid premiums. The continuity  
13 of premium is what provides continuity of coverage; so they  
14 might transfer from a group to a pay contract and to a group  
15 and to another group and still retain their original waiting  
16 period.

17 THE CHAIRMAN: Are there any further questions?  
18 Mr. Walpole, can you leave with our Secretary a copy of your  
19 brief?

20 MR. WALPOLE: Yes.

21 THE CHAIRMAN: And if there is any other informa-  
22 tion that you have which you think might be of interest to the  
23 Enquiry, I am quite confident that they would appreciate having  
24 it. Thank you very much. I think you have made a very major  
25 contribution to the work of the Enquiry Committee.



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1 MR. MULROONEY: I think the Enquiry might be  
2 interested in knowing precisely the area that is covered by  
3 Windsor Medical Services. Do you operate in Essex County?

4 MR. WALPOLE: Yes. The geographical area in  
5 which we operate are the Counties of Essex and Kent in the  
6 Province of Ontario, embracing some 347,000 people.

7 THE CHAIRMAN: Members of the Enquiry, just a  
8 couple of brief items of business. We have had very fine  
9 accommodation here in these council chambers. I think it might  
10 be in order for a motion to be made formally that the Secretary  
11 extend our thanks to the Mayor and the City Council.

12 DR. BUTT: I will so move.

13  
14 ---Whereupon the hearing was adjourned at 3:50 p.m.

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